RURAL HEALTH CARE FOR THE ELDERLY: NEW PATHS FOR THE FUTURE

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UNITED STATES SENATE

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GRAND FORKS, N. DAK.

NOVEMBER 14, 1981

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RURAL HEALTH CARE FOR THE ELDERLY: NEW PATHS FOR THE FUTURE

SATURDAY, NOVEMBER 14, 1981

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Grand Forks, N. Dak.

The committee met, pursuant to notice, at 9:30 a.m., in the Senior Citizens Center, Grand Forks, N. Dak., Hon. Quentin N. Burdick presiding.

Present: Senator Burdick.

Also present: Ann Humphrey, assistant to Senator Burdick, and Kathleen M. Deignan, minority professional staff member.

OPENING STATEMENT BY SENATOR QUENTIN N. BURDICK, PRESIDING

Senator BURDICK. The hearing will please come to order.

This hearing is being conducted today under authority of the U.S. Senate Special Committee on Aging. We have some very important people here that I think should be acknowledged before we start.

We have with us today Martha Torkelson, director of the Grand Forks Senior Center; Marcy Parker, director, North Dakota Consortium on Gerontology, who helped set up this hearing; Eva Quam, aging service regional coordinator; George Keyla, president of the Walsh County Senior Citizens; Ben Gustafson, chairman, North Dakota Council on the Aging; Gladys Black, president, Greater Grand Forks Senior Citizens Association; Helmer Dahlen, president of the Nelson County Council on Aging; and Bernice Puppy, Pembina County Committee on Aging. We also have with us today the White House Conference delegates which will begin in about 2 weeks, Josephine Gustafson, Eleanor Wilcox, and Henry Lundene.

I appreciate your coming here today to discuss one aspect of what I feel will be a major issue in the coming decades. The population of this country is graying. At the beginning of this century, only about 4 percent of the American people were over the age of 65. By the end of the century, the percentage of elderly people will be at least triple that figure. This is certainly nothing to be unhappy about. It is a tribute not only to the medical profession in this country but also to the American quality of life. It will mean many changes in our society, and many of them will be for the better.

Still, the fact is that our growing number of older people will put an increasing strain on our health care system. As the chart here shows, the number of very old people, those over 85, will be increasing fastest of all, and it is these very old people who have the most

problems and need the greatest amount of care. Statistics show that the older citizens use the health care system more, and the older one gets, the more problems one is likely to develop.

Health costs, a growing problem for all of us, are an especially difficult problem for senior citizens. Recent figures show that medical costs went up 15.8 percent in 1980. Medicare, however, shot up even more, 21.4 percent. And I can tell you that these costs are causing serious concern in Washington, where the desperate efforts to balance the Federal budget are being stymied by the continuing growth of entitlement programs like medicare and medicaid. We have to find new ways of providing quality care that are not going to break the bank, and this is one of the major purposes of this hearing.

Too often, older people are sent to nursing homes because their problem has been misdiagnosed or, worse yet, because there is no other alternative available. Forty-five percent of the Federal medicaid budget goes toward nursing home care, and this is a budget that is expected to quadruple by 1990.

Yet, there are all kinds of alternatives that would be better for all concerned, alternatives that could provide the elderly with the care they need without taking away their independence. These are the kinds of programs we must seek to develop. Unfortunately, it is just these kinds of programs that can be especially hard to develop in rural areas. Over one-third of America's older population lives in rural areas. They not only have all the problems of their urban cousins, but they also face continuing problems of rural health care, inadequate transportation, chronic shortages of health professionals, a lack of support services. I could go on and on. Suffice to say that almost half of North Dakota's counties are officially designated health shortage areas, and eight do not even have a practicing physician.

The chart here shows wide discrepancy in the numbers of physicians in urban and rural North Dakota: 80.3 percent of our physicians work in the 10 most populous counties, leaving only 19.7 percent of the doctors to serve the 43 percent of the population who live elsewhere.

These problems and possible solutions to them are what we will be talking about today. Our first panel will discuss the problems as they have seen them and experienced them, and our second panel will respond. All members of the second panel have a special concern for older citizens and two, Dr. Butler and Dr. Reiff, have devoted their careers to them.

I want to thank all our witnesses for coming here today, especially you who have come from long distances. At the end of the hearing, after all the witnesses have testified and I have asked some questions, I will open this up to take questions and comments from the audience. Also, there are forms in the back of the room on which you can also write out your comments. The record for this hearing will remain open for some time, at least until November 30, and comments received by that time will be included in the hearing record, so all of your questions, oral and written, will be made a part of the record that will go to the committee in Washington.

Now I would like to introduce the panel members. On panel No. 1 is Henry Lundene, of Adams, former State legislator and senior citizens activist; also on panel No. 1 is Art Tweet, of Grand Forks, former nursing home administrator, now retired, and living at Tufte Manor; Dr. Henry Janssen, Linton, physician; and Sister Joanne Wieland, Rolla, administrator of Prairieland Home Health Agency, Rolla.

Those on panel No. 2 will be Dr. Robert Butler, Director, National Institute on Aging, Washington, D.C.; Dr. Robin Staebler, chairman, Department of Family Medicine, University of North Dakota Medical School, Grand Forks; Dr. Theodore Reiff, director, institute of gerontology and geriatric medicine, University of North Dakota, Grand Forks; Dr. Kevin Fickenscher, director, office of rural health, University of North Dakota Medical School, Grand Forks.

I think we have some very prestigious people here today to testify. So now we will start with panel No. 1. I would like to call first upon Henry Lundene to lead off.

STATEMENT OF HENRY O. LUNDENE, ADAMS, N. DAK., FORMER STATE LEGISLATOR AND SENIOR CITIZENS ACTIVIST

Mr. LUNDENE. Thank you, senior Senator Burdick.

My name is Henry Lundene, and as a rural resident of North Dakota, the most rural State in the Union, and as a senior citizen and one active in the senior citizen movement, I suppose I should be qualified to fill the position in which I now find myself, speaking on the problems of the rural elderly, and more specifically on the delivery of health services to them.

I have looked long and hard at the subject assigned to me, also at my fellow panelists, and the brief time allotted for me to speak. I want to speak briefly on the topic of which I am most familiar, that of our own countywide senior citizens and how we attempt to accommodate them.

We do have a countywide senior citizen bus which crosses the county four times weekly, providing only mediocre transportation service, but the only service outside of the private automobile.

With 11 organized senior citizen clubs geographically organized in Walsh County, we do provide at least a portion of the recreation requirements of the 18,000-plus population.

With a countywide nutrition program, serving dinners at eight separate locations in the county, we do provide balanced nutritional meals to some of the elderly in Walsh County.

Our great failing is to provide homemaker and health care services to the elderly in their homes. We do have in our county a very limited homemaker service maintained by our county social service which has been cut back recently and threatened by total extinction. There is really no concern shown for health needs and care of our rural elderly who are unable to attend to their own needs.

Many of our people are forced out of their homes, where they prefer to stay, for lack or health care, to become residents of rest homes, before they have reached the stage of infirmity. Invariably, in their own homes is where they prefer to stay, and at a much lower cost.

In the rest home, their resources are soon gone and they are deprived of their independence, which most of them prize so highly. It seems strange to us natives in the rural areas that no assistance or funds are available for the benefit of our elderly in their homes. Yet, when they must go to a rest home, social welfare will pay huge amounts for the care they receive as a patient, losing all of the comforts of his own home, his dignity, self-respect, and decisionmaking prerogatives.

Again, in my county, an area of 36 townships, or about 1,300 square miles with approximately 18,000 population, we do have a county seat and another fair-sized city where we do have medical services, but many of my Walsh County people must somehow find transportation 35 miles or more, and then sit for hours in an uncomfortable waiting room, and pay from $12 to $16 for a blood pressure test or other minor medical service. If they are unable to contact the senior citizen bus, then many must impose upon friends and relatives which makes several of them hesitant.

Today, I am aware that I am in an enviable position. I can impose on my hearers serious situations and difficult questions. I sympathize with you lawmakers who must find answers to tough questions. On a lesser degree, I have also been in your situation.

I have made the unpopular statement to my doctors that I did not believe the medical colleges put enough time to training their students for the hoards of elderly that will be waiting for them when they begin to practice. I am dismayed as a member of that group past 65, and I have shocked some of my good social service workers by saying I did not believe our colleges were preparing their students in social service for the high percentage of elderly that would require their special skills in social service. Many of our workers mean well, but they have never been included or are aware of the problems of the elderly.

I have even told my pastor that I question if the seminaries educating, training, and turning out pastors and priests are giving their students the type of training they really need when they face the world, and the gaining and the growing number of elderly in their parishes.

I am dismayed, as a member of the senior citizen group, at the cost of my varied health service insurance benefits and yet, even though I pay out about $8 per day in health service premiums for the wife and I, I wind up paying part of the clinic bill out of my own resources. If I seek relief from my chiropractor or massage therapist, I find their fees are disallowed by my policy. These are the practitioners so often consulted by the elderly for rheumatic and arthritic pain.

Several counties, of which there are 53 in North Dakota have no doctor or hospital facilities within their borders, but these areas contain their share of elderly on the farms and in small towns, many of them in single person homes.

I was pleased that the eastern-western North Dakota district convention of the American Lutheran Church held in July 1981, had as their convention theme, "The Problem of the Elderly." The convention program revolved around that topic.

I did procure a taped copy of the remarks made by Dr. Michael Hendrickson. I believe when a leading church denomination becomes

aware of the problems, then the problems become surfaced and emphasized. Dr. Hendrickson says that no part of our population is growing like that of our elderly and the very old.

The social security programs, as administered, cannot and must not be ignored, and not many things are more sacred to the persons receiving these monthly checks, or the middle-aged who have paid their premiums religiously, with the firm belief that this would be their lot later in life.

No doubt, unemployment is the culprit, No. 1, with many persons anxious to get out of the labor market and not enough persons paying, compared to those receiving monthly checks.

The agricultural producer, where much of our wealth comes from, is experiencing not only a recession but also inflation.

In my closing remarks, I would be amiss if I did not say something about the most atrocious thing that is now happening in our community and no doubt many others. We have had several of our elderly afflicted with terminal illness committed to our hospitals and after a given time, regardless of their physical condition, they or their relatives are told that their time is expired so they must move. This happens regardless of their condition or age, the patient's insurance coverage, ability to pay, or physical condition. Several dying persons have been forced out over the objections of the relatives of the patient, no matter what the financial resources of the patient, the physical condition, or the empty beds in the hospital. Several have been bounced over highways to homes 75 and 100 miles away, only to die within hours.

Recently, a World War I soldier got this same kind of treatment. My community is furious over this kind of treatment. After all, we who have reached old age or approaching it can expect no different treatment, and we consider ourselves a Christian Nation. Whatever happened to empathy?

Thank you.

Senator BURDICK. Thank you, Henry.

We are going to pass on to the next panelist, but do not get the idea you are not going to be questioned because you are going to be cross-examined, too.

Mr. LUNDENE. OK.

Senator BURDICK. Art Tweet, Grand Forks.

STATEMENT OF ART TWEET, GRAND FORKS, N. DAK., FORMER NURSING HOME ADMINISTRATOR

Mr. TWEET. Senator Burdick and distinguished members of this panel, I am not here to quote any statistics. I am not here to plead any cause except one this morning.

In 32 years of experience as an administrator or president of the board of the Valley Memorial Home, you naturally arrive at some decisions, some opinions, and some judgments as to the efficacy of the services being given to the older people at this time. And I am concerned this morning over the trend or a new toy or a new idea that has sprung up in the last 4 or 5 years, and that is the thing that was touched upon just now, having to do with what do we do

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about caring for the people who reach the age of 65, but now most of them running up around 80 or 85.

We have one man in our home at 98. We have a woman in our home at 97. We have many people that age. Now, the past experience has been this, that those older people need supervision. They need personal contact. They need understanding of their mental slowness and their mental or physical disabilities. They need an understanding of what life is all about for these older people.

I also find that these older people have found themselves in a feeling of loneliness, all alone, and so when we talk about caring for the older people and keeping them in their own home as long as possible, I want to warn you that there is a hazard involved there.

I give you two illustrations of what I mean by that. One, we had a man in our home as a patient. His wife came to see him every day but continued living in their home. One day she did not come and the nurses did not think too much of it. The second day she did not come and they wondered what happened, so they tried to call the house. No answer. They called the man who was looking after her business affairs, and he went to the house and could not get in, so he got a policeman to come with him and they broke in and found her on the floor of her living room dressed only in a nightgown, and she had been lying on that floor for 48 hours before she got help.

I want to tell you that that is one of the hazards that if we overdo and carry this program to the extreme, it is a danger to the lives of these older people, and we need to protect ourselves. I am not quarreling with the idea of staying in the home as long as possible. Heaven knows, they have a sentimental attachment to that home. It has been their home for years and years and years, and they feel reluctant to give this up.

On the other hand, you are dealing with a life surrounded by hazards, falling down, breaking a hip, being left alone, and even if the visitor, the nurse or the visitor, calls on them and they have to wait another 24 hours before they see anyone—15 minutes after that care, the person leaves that home, you can find yourself with a person on your hands who suffered a stroke 15 minutes after you left there.

I want to point out the hazard, and we must safeguard that part of it in our planning. Another factor involved here is the loneliness or being alone. I will give you another case history.

A woman who was on the faculty of the University of North Dakota for years lived in her own home after her husband died. The wives of the professors tried to look after her as best they could, but she found long stretches of time in which she was alone, and after a while her mind became confused, and they decided that she must be brought to a nursing home. They brought her to the Valley Memorial Home and we took her in. She was mixed up. She was confused. But she found herself surrounded by people, which was her normal activity in life. We took her to the activity room and she started making things, and after 6 months her mind was clear and she simply carried on life as it had been before she had that stretch of loneliness living alone in her own home.

I see there is a hazard in carrying this program too far. Up to a point, fine, but let us make sure when they need care it is there.

I have another problem that I think is quite important to the older people, and that is this: I would like to deregulate the regulators. I would like to have some sense of financial responsibility on the part of those who make these regulations.

The most glaring example I know of happened right here in Grand Forks. We built a new skilled nursing center out at Medical Park with 160 beds. We started taking patients in February and now it is full, every bed is taken. We were carrying—we had that nursing load down at Valley Memorial Home on Almont Avenue. We were licensed by the health department to take care of skilled nursing people, nursing care people, and yet when we moved into that area designed by the government as intermediate care, which is less than skilled care and more than custodial care, in other words modifying the program according to the needs of that particular individual. It satisfied the health department that this building was entirely satisfactory. The regulator came along with new regulations for intermediate care, and this nursing home that was good enough to take care of skilled nursing people now was declared deficient in makeup, and we are spending $350,000 to satisfy the demands of the regulators.

I would like to deregulate these regulators. This $350,000 is significant in this respect, that every single time that you add an expense in caring for these people, the sick and the old, elderly people have to pay for that, and I would like to say let us take a look at these regulations to see whether it is costing the sick and elderly people something of their lives.

I have only one other thought in mind and that is this, that much as we are concerned with legislation, funding, programs, and that kind of thing, let us keep in mind that we are dealing with a person, an individual. Let us operate in such a way that the older people feel they have their dignity, feel that they have their self-respect, feel that they are beloved by those who serve them.

The individual is the prime person involved in our program, of all programs. Let us keep that in mind. Let us always be aware of the time that these older people are our responsibility to meet their needs.

Thank you.

Senator BURDICK. Well, thank you, Mr. Tweet.

Our next panelist is going to be Sister Wieland—no, excuse me.

Sister WIELAND. I am sitting in the wrong place.

Senator BURDICK. You are sitting in the wrong place, but we will take you, Sister. Sister Joanne Wieland.

STATEMENT OF SISTER JOANNE WIELAND, ROLLA, N. DAK., ADMINISTRATOR, PRAIRIELAND HOME HEALTH AGENCY, ROLETTE AND TOWNER COUNTIES, N. DAK.

Sister WIELAND. I appreciate this opportunity to speak about the problems facing the elderly in the rural areas. It is of deep interest to me.

As director of Prairieland Home Health Agency in Rolette and Towner Counties, these problems face us daily. I would like to deal with three areas—education, home services, and transportation.

The elderly themselves need to know more about aging and how it affects their bodies. They lack information on diet and medication. Often, they do not understand the purpose of medications prescribed for them, the possible side effects, and even the importance of taking them as ordered.

Clinic visits and home health services could be useful to help maintain and promote health, and on many occasions to prevent crises and hospitalization.

I think in the 3 years that I have been working in Prairieland Home Health Agency, that I would have enough statistics to show that elderly people who are frequently in the hospital, when put on home health, reduce the amount of hospitalization and the length of stay is decreased.

Education is needed in the availability of services which would help them continue to care for themselves and preserve their independence as long as possible.

Those who deal with the elderly o nonprofessional level and on a professional level, the staff, nurses, physicians, and social workers, could profit from workshops and courses on aging and available home health services. Often, it is these people that must take the initiative of referring patients to home health services.

A head nurse from an acute hospital told me just last week, "Yes, I was thinking she would be a good candidate for home health," but this is as far as she went. There frequently is no followup from hospital care. It is necessary for professionals to see the total picture of health care services available and to work together to provide the best possible care for the elderly person. It is they who must take the initiative in seeing that these services are provided for. It may be just the services of a home health aide or the services of a homemaker.

Nursing school curricula could emphasize care in geriatric nursing and practical experience in this field. An understanding of good mental health is essential, too. A nursing home resident's problems may be the fault of the staff's attitudes. I see limited services to professionals and paraprofessionals in understanding the needs of the elderly, and their own needs and skills, and how they enter into the care of the elderly.

Home health services need to be extended and utilized to a greater extent. This might be brought about if there were reimbursements available for physician visits to the elderly in their homes.

Another limiting factor is that medicare will not reimburse for homemaker or aide service, whereas these are often the cares most needed if the elderly are to remain at home. Simple physical tasks, such as nail and hair care, and homemaker services, such as vacuuming, making beds, and washing clothes, which require more physical strength, this is all they need to stay at home.

There is need for more volunteer service in communities to help the elderly, visiting the elderly who are alone most of the time, and many times are lonely and depressed. The communities of small towns and rural areas offers a resource which interested people and health care professionals could use in organizing services for the elderly.

An example, I had a lady who had terminal cancer, wanted to stay at home. Her pain was increasing so she needed increased injections, every 3 hours. Our agency could not provide this service. I talked to the right

person and within a day she had six nurses lined up who had volunteered to go in to give her injections when she needed it. I think there is a resource there that we are not always aware of.

Because the elderly are often alone, and their children are married and away from home, they often have to depend totally on their own capabilities for meeting their needs. Because of poor eyesight and slower reaction time, they have difficulty driving. There are a number of older people driving through necessity. Small town people often recognize these individuals and adjust their own driving habits to protect the older person and themselves.

A community service to protect the older person—a community service of providing transportation would be a definite help for the elderly. They need transportation to and from the clinic, the grocery store, social events, and to church services. I know some towns have transportation supplied to elderly, but they do not have it for church services, and sometimes, for the elderly, this may be the most important service they would want.

Other problem areas of rural health include a need to review and revise medicare and medicaid regulations. These regulations should be available in lay terminology. A lot of our home visiting is clarifying or helping the person to understand medicare laws and medicare terminology. Nursing home information should be readily available. Health care costs, costs of going to the clinic for minor problems, medication costs, are great concerns of the elderly. I know some elderly who cut their food budget to pay for the medications.

Another large area not talked about is the general public's attitude toward the elderly, lack of concern by relatives, negative attitudes which promote dependency, "stick them in a nursing home" attitude. If people are to be kept independent at home, social activities need to be provided for them in their home.

Housing is another area. There is a group of elderly who do not qualify for nursing home care, yet they cannot live by themselves and need some other safe living arrangements.

These are some of the problems I see that we all face in order that the elderly may receive more adequate care, and remain independent, and live more fulfilled lives.

Senator BURDICK. Thank you, Sister Weiland.

Dr. Henry Janssen, Linton, next witness.

STATEMENT OF DR. HENRY P. JANSSEN, LINTON, N. DAK.

Dr. JANSSEN. Mr. Chairman, fellow panelists, ladies and gentlemen, as this society approaches the 21st century, as Senator Burdick has already pointed out, a larger proportion of our population is going to be over 65. As these numbers tend to increase yearly, it is a natural process that our services should be geared toward the highest percentage of the population. This is certainly why a hearing like this is being held.

Problems of the aged are both universal and unique. Just as pediatrics is a specialty upon itself, geriatrics should also be considered a specialty unto itself. As children have unique problems, so do older people have unique problems.

The problems of the aged in the rural society seems to be more amplified than those of the urban population, for several reasons. In the rural areas, there tends to be a greater proportion of the population that are aged, mainly because of the fact that many of the farmers in a rural area will migrate to a small town or village upon retiring off the isolated farm area.

However, this is not true for all elderly in the rural areas. Many of the farmers will plan to spend their last few years in relative isolation. This makes health care in the rural area extremely difficult. The accessibility to health care and other essential services are difficult, just from the sheer fact of distance to the facilities.

In my 2½ years of practice, general practice in Linton, N. Dak., which is in Emmons County in the southern part of the State, I have noticed that practicing good quality health care on the aged is quite difficult, for many reasons.

Many of my patients—and it is logical to assume that this is universally true for most elderly in rural populations—are quite independent and want to maintain their independence as much as possible. They are often brought to the clinic by their children, very ill, extremely malnourished and, through no fault of their own, ignorant of their physiologic processes and wellness.

I believe part of this ignorance is due to the lack of communication between the elderly and the health care professionals. In my presentation, I would like to state my own views on how I feel the problem of caring adequately for the elderly in the rural setting is best achieved, and what must ultimately be done to keep the rural elderly healthy, wealthy, and wise.

It has been the trend in medicine, at least in the last 15 years, that more stress be put on preventive medicine. This is true not only for the young, for whom we are giving immunizations and routine physical examinations, but I think it also must extend to the elderly, with routine blood pressure checks, simple outpatient laboratory investigations, and simple health screening techniques done by either nurse or physician.

The saying, "An ounce of prevention is worth a pound of cure" is extremely applicable to the elderly. Many physicians despair when they see elderly people who have extremely high blood pressure because they feel that the patient has had hypertension for many years, has not been diagnosed, and untreated, thereby dooming the patient to severe cardiovascular, cerebral vascular, and kidney disease. However, newer medical data now points out that the treatment of both high systolic and diastolic blood pressure is extremely beneficial to the elderly for slowing the processes, and at least delaying the acute catastrophic health disaster.

The accessibility of this simple health screening technique has improved in the last few years, but we must reach out to get more of the isolated people in the rural communities. I feel that the public health nurses, as well as primary health care physicians, must make a concerted effort to go out and seek these people.

The ultimate goal of this outreaching hopefully will be to educate the elderly on the importance of health maintenance and preventive care, thereby preserving their wellness.

I wish to underline again that education of the elderly about these preventive measures is extremely important. A well organized, systematic approach to this education is as important as education itself. If a haphazard attempt is made to sloppily educate a few, it would be worse than a doctor practicing shotgun medicine.

In Emmons County, we have been lucky enough to receive a small grant, which is all that is really necessary, to hire a registered nurse to carry out routine blood pressure checks and foot clinics, as well as doing simple estimations of serum glucoses to rule out diabetes in our senior citizens clubs in the three small communities that we have in Emmons County.

There has been an extremely good response to this service; however, I cannot help but believe that there are many more people not taking advantage of this service than there are using it.

It is this segment of our population, the people who are not actively seeking this sort of service, that we should be aiming our efforts at. If the preventive medicine approach is not used, then we are going to have a large proportion of our population that is quite ill, and not able to enjoy life, and contribute to life to their fullest potential. This will certainly tax our acute health care system beyond its limits.

As our health care system rapidly approaches 10 percent of the gross national product, it should be inherently obvious to most of us here that preventive medicine and education to the public about their own wellness should be stressed.

It has always been a basic contention of mine that we must all assume responsibility for our own bodies and health care. However, if everyone is to assume this responsibility, they at least have the right to the education about their wellness.

As I have mentioned before, one of the chief problems of living in a rural area is the difficulty of accessibility to health care due to lack of transportation. Many family physicians are quickly finding out the era of the house call is over. This is because the physician needs many auxiliary services to diagnose disease properly. If this continues to be the trend, then our goal should be to provide transportation for the elderly to screening areas where larger numbers of people can be dealt with more effectively. This would give many people such a place to exchange experiences and ideas about their health care.

To make this more attractive to the elderly and to make it less threatening, it may be a good idea to combine these screenings with such social activities as arts, crafts, cardplaying, conversation, or teas. This type of event could be held at community centers, senior citizen clubs where large numbers of the elderly could be transported via bus or even mobile home.

If this was successful enough and enough people enjoyed it, the system would be self-perpetuating without loss of followup of many of our patients. In my experience, I have found that one of the major areas of health care that has been ignored by the elderly, either because of financial considerations or physical limitations, has been nutrition. The adage, "You are what you eat," becomes extremely important to a body that is not finely tuned.

Again, education plays an extremely important part in this area. I also believe that efforts must be made to provide some sort of nutri-

tional aids such as a meals-on-wheels program, where a van full of prepared nutritious food is brought to the elderly on a regular basis. If a large enough segment of our population could be included in such a program the cost could be kept to a minimum. However, some sort of subsidy from either local, State, or Federal Government would probably be necessary.

I am sure that all of you would agree that this is an excellent idea. However, the logistics of doing it often becomes very difficult in the rural area. It has been done quite successfully in various parts of Canada and the United States, so we know it is not impossible.

The issue of nursing homes was never distasteful to me until I began practicing medicine. It always seemed great to me, as a medical student, when I got older and no longer could look after myself I could go to a home where I could get three squares a day, have someone look after me, make my bed, play cards, and shoot pool all day.

Since I have been practicing medicine now, the stark reality of what a nursing home means to an old person has become painfully obvious to me. Most patients view the nursing home as the final place of rest where all hope is lost. "The family has decided to abandon me and I have been sent here to die."

In part, we are responsible for this attitude, because in fact, that is why we are sending the person to the nursing home, to get them out of the way, to make them less bothersome, so we do not have to be responsible for their care.

The two points that I would like to make about nursing homes are, first of all, that there are not enough beds in nursing home bed facilities in the State of North Dakota and, second, the exposure to the nursing home beds must be changed somewhat.

To add some clarity to my statements, let me start off by making a general statement about institutionalization in general. It has always been quite disturbing to me that institutionalization tends to take individuals that are already compromised and compromises them even further. We are taking individuals who are somewhat disabled, stripping them of their independence, and making them as uniform as possible.

The reason we are trying to make these patients as uniform and docile as possible is that it is easier for a small number of staff members to handle them. I personally have seen this in a mental institution where I worked as a student for 5 years. I saw patients come into the institution who were relatively bright and productive made into docile, conforming machines.

In order to combat this trend, I believe it is necessary to make the institution as stimulating as possible by fostering independence. A Ph. D. in psychology is not necessary to carry out such a program. Educating the nursing staff and social workers of such an institution would be a great step forward. Simple matters, like making the patients dress themselves in the morning, making their beds, and choosing what they would like to eat, as well as getting them involved in daily decisionmaking processes would help in breaking the humdrum routine of an institution, regardless of its size.

Another positive possibility to make institutions less monotonous is to give the patient an opportunity to generate some income through

arts and crafts. I am not advocating a sweatshop where little old ladies have to produce 500 knitted doilies a day; rather a relaxed atmosphere where some sort of stimulating activity to help maintain perceptual motor coordination could be available.

There are several large industries in this country which require such work. As well as being a tremendous public relations device for them, it would also give the elderly an opportunity to maintain activity. Some of the high costs of nursing home care could also be offset by their own work.

Other devices which may be used in a nursing home and which have become quite popular in the nursing home that I am in charge of are orientation devices. These involve simple techniques such as recording the day of the month on the wall so the patient could see it when he gets up. This is excellent for patients as well as the doctor who is doing rounds that particular day, as often I don't know what day it is, either.

My final comment pertains to the education of the health care professionals regarding geriatrics. It has often been stated that health care professionals at all levels in the past have found it distasteful to work with geriatrics for various reasons. They don't want to hear that one day they may grow old, that they have a sense of hopelessness because the elderly patients are sometimes slow to respond to medical treatment.

I believe that in order to approach this problem effectively we must start at the grassroots, that is, medical school, nursing school, and other health care professional education institutions.

As little as 5 years ago, most of us received just a very brief smattering of geriatrics in our medical curriculum. There obviously has to be a major revamping of the medical school curriculums where an active department of geriatrics has time enough to educate students regarding problems and care of the elderly.

This should be extended to the actively practicing physicians to keep them up to date on problems and care of the elderly through literature and symposiums.

One of the first areas that should be approached for the novice and the practicing physician is how to communicate effectively with the elderly. In dealing with the elderly, I believe that we need to take a little extra time, and be extremely patient, because they become quite embarrassed quickly and introverted if pressured by a very aggressive investigative approach.

Therefore, ladies and gentlemen, in conclusion, I would like to say that practicing medicine in a rural community can be extremely rewarding for both physician and patient. In the future, the physician must be able to cope with varied types of problems, not the least of which will be the problems of the elderly. A major revamping must be carried out with respect to our approach to the care of the elderly, with emphasis being placed on preventive medicine, establishing an attitude of worth and hope in the elderly, and making health care delivery systems accessible with various techniques.

As I have stressed many times in my presentation, education of both the patient and the health care professional is the focal point

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for the care of the elderly. If we do not prepare ourselves now for the major onslaught of the elderly in the future; that is, the very near future, we will find ourselves totally unprepared physically and mentally to deal with the enormous problems that we will be facing. I hope that members of the second panel will confront some of these problems, and we as the health care professionals, will follow on their suggestions.

Senator BURDICK. Thank you, doctor.

Well, we have heard some of the problems on panel No. 1 on my right. Panel No. 2 is going to endeavor to give us some answers, and so we are going to start now with Dr. Butler.

STATEMENT OF DR. ROBERT N. BUTLER, WASHINGTON, D.C., DIRECTOR, NATIONAL INSTITUTE ON AGING, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. BUTLER. It is a very great pleasure for me to be here. What I would like to do, Senator Burdick, if I might, is submit my formal statement to you for the record and just give some highlights from that testimony.

Senator BURDICK. Your full statement will be made a part of the record, and that goes for all members of the panel. Your full statements will be made part of the record. As I say, all statements will be received in this manner until, at least until November 30.

Dr. BUTLER. It is very valuable to me to travel away from the ivory tower of the National Institutes of Health in Bethesda and see what everyday realities are. I am very happy to be here as it is something I have always wanted to do, to visit in this city. Speaking from the national perspective, which encompasses 50 States and 126 medical schools, I submit that we are in deep trouble with regard to health care for older Americans. I agree very much with what Dr. Janssen had to say, as someone who is practicing directly in the community.

Again, from my national perspective, I think we have a very good leadership of experts, consultants, teachers, innovators, and researchers who are committed to best serving the health needs of older Americans.

I think we are in real trouble as a result of our failure to meet such human needs, and also because of rising health care costs which are very, very difficult for both individuals and society to support.

We can contain health care costs through learning new ways of early detection and better diagnosis and treatment of the illnesses and conditions of older people. We must also find techniques for appropriately placing individuals in nursing homes, while at the same time being certain that we upgrade nursing homes and other facilities when this is required. We must also introduce strategies for disease prevention and health promotion in nursing homes and outpatient settings.

There have been two recent major reports, one from the Institute of Medicine of the National Academy of Sciences and another from the Rand Corp., which describe the awesome needs for leadership in the field of geriatrics and project future needs. It has been most reassuring to me to hear frequently from medical students and from the

American Medical Association, to hear that they too recognize the need for training in geriatrics. Most of all, however, I hear from older persons themselves. In fact, thousands of letters have reached the National Institute on Aging from people who point to, as Mr. Lundene did, the great needs of older persons and their families. This fact is true in both urban and rural areas.

We cannot give the names of physicians who are expert in the field of geriatrics in response to these inquiries, because they simply do not exist. However, we have prepared a National Institute on Aging fact-sheet on the rural elderly, with today's hearing in mind, to try to delineate some of the key issues affecting older persons in such States as North Dakota.

There has been some real progress in the medical schools. For instance, there are the beginnings of endowed chairs in geriatrics in American medical schools, for example, at Cornell University, and a number of schools have competed successfully for the National Institute on Aging Geriatric Medicine Academic Award. Some 22 medical schools, among 70 applicants, have competed successfully for this award. Harvard, Yale, the University of California, and the University of Vermont, are among grantee institutions.

The National Institute on Aging has also been trying to encourage dentistry to expand its horizons in meeting the dental needs of older Americans. And, just recently, we announced the beginnings of what we call the Teaching Nursing Home Award in order to develop academic environments in nursing homes for medical, nursing, and other health professional students so as to increase their knowledge and provide opportunities for research.

Again, Senator Burdick, it is especially pleasant for me to be here. You have been a long-time supporter in trying to develop geriatrics through legislation, so I know you very much appreciate my concern for North Dakota, and for the Nation as a whole, in finding the necessary leadership to meet the health needs of older persons and their families, as well for finding ways to contain rapidly rising health costs.

Thank you very much.

Senator BURDICK. Dr. Butler, we certainly appreciate your being here.

[The prepared statement of Dr. Butler follows:]

PREPARED STATEMENT OF DR. ROBERT N. BUTLER

Mr. Chairman and members of the committee, I am pleased to testify at this field hearing of the U.S. Senate Special Committee on Aging on the subject, "Rural Health Care for the Elderly: New Paths for the Future." I will share with you today some highlights in the development of training in geriatric medicine, and particularly the role of the National Institute on Aging (NIA) in fostering activity in this area.

Much progress has been made since the first time I testified on this subject, on October 13, 1976. That hearing, "Medicine and Aging: An Assessment of Opportunities and Neglect," was also sponsored by the Senate Special Committee on Aging. However, while progress has been substantial during the last 5 years, many challenges remain in preparing physicians to meet the great needs of our Nation's older population.

Although people age 65 and over account for a disproportionately large share of physician time and health care dollars, most physicians in the United States are inadequately trained in geriatric medicine. While interest in the prevention,

diagnosis, care, and treatment of illness and disability in older people is increasing, some medical schools still do not offer courses in geriatrics. Even fewer schools provide clinical experience in the community, hospital, or nursing home with older patients who are generally healthy as well as with those who are chronically ill. This situation exists despite the fact that when physicians are knowledgeable about the special considerations in treating older patients, health care costs are contained. Early disease detection reduces complications, shortens hospital stays, and reduces nursing home admissions. Cost reductions also occur as laboratory and clinical research on aging result in improved diagnosis and treatment, even prevention, of the diseases of old age.

Recent studies by the Institute of Medicine, part of the National Academy of Sciences, and the Rand Corp. have delineated training needs in geriatric medicine. In September 1978, the Institute of Medicine published the findings of an NIA-commissioned study examining the need for teaching of geriatric medicine and the extent to which geriatrics is already offered in medical schools curricula. The report, entitled, "Aging and Medical Education," suggested several ways to incorporate geriatric training into the education of every medical student, intern, and resident, as well as into the continuing education of practicing physicians. The study called for the development of a core of faculty members to teach geriatrics; inclusion of information on geriatrics in basic and clinical courses; requirement of one course on aging in undergraduate medical education; and provision of clinical experiences for residents in long-term care facilities. It was also recommended that questions on geriatrics be placed on examinations for certification and licensure, and that geriatrics receive increased attention in continuing medical education programs.

Most recently, in May 1980, a study of geriatric manpower needs, funded by the Rand Corp. and the Henry J. Kaiser Family Foundation called for the development of both academic and practicing geriatricians. Projecting that between 7,000 and 10,300 geriatricians will be needed by 1990 to adequately serve the elderly population, the study recommended redistribution of physicians among specialties rather than an increase in the total number of physicians.

Medical students, too, have voiced their concerns regarding the needs of the aged. In response to an upsurge in interest, the American Medical Student Association (AMSA) organized a Task Force on Aging. Among other activities, the association has developed a guide for "Curriculum Development in Geriatric Medicine," circulates the "AMSA Task Force Newsletter," and published a "Clinical Geriatrics Training Sites Directory."

Older people themselves want improved health care, demanding an end to the short shrift they have received from the medical community. The NIA has received many letters and phone calls from older people and their families concerning inadequate medical care. In response to numerous requests for the names of qualified physicians skilled in the treatment of elderly patients, we have had to reply that, at present, there are very few physicians with experience in geriatrics—and that these individuals are largely self-taught.

The NIA, charged with coordinating studies on the processes of aging and the related training of personnel, has sought since its establishment, to foster the development of training programs in geriatric medicine. In 1978 the NIA established a geriatric medicine academic award program designed to stimulate faculty and curriculum development in geriatric medicine and research. In addition to encouraging the development of quality curricula in geriatrics, the award is intended to develop promising young faculty with interest and training in geriatric medicine, with particular emphasis on geriatric research. The NIA is now providing support to one individual in each of 22 U.S. medical schools. Competition is so keen that the quality of the awards has never been higher. In order to assess the effectiveness of this program approach, the NIA is now developing the methodology for a comprehensive evaluation of this training program. However, we already know, based on reports of our geriatric medicine academic awardees, that the granting of the award itself has given credence to geriatric medicine and facilitated the task of building a program of geriatrics at their institutions.

In October 1979, the NIA announced a Geriatric Dentistry Academic Award aimed at promoting the development of a curriculum in geriatric dentistry in those schools that do not have one, and to strengthen and improve the curriculum in those schools that do. The NIA is currently supporting individuals in six U.S. dental schools. This award was established in response to the great need among

older people for improved dental care, particularly since overall health among the elderly is dependent on good oral and dental hygiene. Through the stimulation of geriatric dental research, the NIA hopes to ultimately contribute to improved dental practice.

Several other NIA-sponsored awards are also aimed at strengthening training in geriatric medicine. The NIA Academic Award, established earlier this year, is intended to bridge the gap between the initial period of postdoctoral study and a formal academic appointment for individuals with higher potential for research and teaching careers in clinical areas. This award gives highly qualified young physicians the opportunity for 5 years of special study and supervised experience.

The Clinical Investigator Award offers funds enabling the recipient to make the transition from clinical training to do a career in independent biomedical research.

The special initiative grant fosters high-quality research in gerontology by supporting pilot studies leading to the creation, expansion, or modification of programs in aging research and training.

Another relevant award, sponsored by the entire National Institutes of Health, the Short-term Training Award, is designed to attract highly qualified students into biomedical and behavioral research careers. This program is intended to offset the trend away from research careers among students in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacology, and podiatry.

Just this week, the NIA formally announced the initiation of the teaching nursing home award program. This program will support research by academic medical centers and nursing homes on geriatric health problems in nursing homes and other clinical settings. A major goal of the program is to encourage research on health problems which are particularly prominent in nursing homes and among geriatric outpatients, rather than in acute care hospitals. The program also seeks to develop research on current and new therapies and health maintenance strategies in nursing homes and geriatric outpatient settings, as well as in acute care hospitals.

The NIA has established the teaching nursing home program because knowledge stemming from research is sorely needed on a number of diseases and conditions prevalent in the older population, such as dementia, sleep apnea, incontinence, fall injuries, and musculo skeletal disorders. The program will also support the investigation of therapeutic interventions aimed a, increasing patient independent functioning within the nursing home setting, as well as preventive, rehabilitative, and prosthetic strategies for the amelioration of chronic disabling conditions. Ultimately, the teaching nursing home award program will increase and refine the body of knowledge in geriatric medicine through clinical research, and, therefore contribute to the building of a sound and responsive health care delivery system for the aged.

The Teaching Nursing Home Award is administratively structured to provide support for research projects by members of participating institutions and research and administrative activities by the center core staff. The maximum initial duration of the award will be 5 years, with the possibility of extending an award to a total duration of 8 years through competing renewal applications. For further information on this award program, please contact the NIA, Bethesda, Md. 20205.

In summary, a medical profession well-versed in geriatrics can benefit society in two important ways. First, older patients and their families will benefit physically and psychologically by more efficient treatment and more compassionate care given by sensitive and knowledgeable health practitioners. Second, a better understanding of the principles of geriatric care by health professionals will greatly reduce society's health care costs. Through the programs I have briefly reviewed, the NIA is seeking to meet the challenge and opportunity presented by geriatric medicine and training.

This concludes my testimony.

Senator BURDICK. Dr. Butler, You referred to a factsheet on rural elderly?

Dr. BUTLER. Yes.

Senator BURDICK. Would you make that available to the hearing record?

Dr. BUTLER. I would be very happy to do that, sir.[1]

Senator BURDICK. Thank you.

Our next witness will be, in line I presume, Dr. Reiff.

STATEMENT OF DR. THEODORE R. REIFF, PROFESSOR OF MEDICINE, ADJUNCT PROFESSOR OF RELIGIOUS STUDIES, AND DIRECTOR, INSTITUTE OF GERONTOLOGY AND GERIATRIC MEDICINE, UNIVERSITY OF NORTH DAKOTA, GRAND FORKS, N. DAK.

Dr. REIFF. Senator Burdick and fellow colleagues in aging, and I really mean that because, as Dr. Butler has said, the aged are our future selves.

Until recently, medical school curricula in the United States have included little or no education and training that is specifically geared to increasing the special knowledge that is required for effective care of the unique health problems of older persons.

In the early seventies, a group of medical educators from medical schools throughout the United States gathered at an annual meeting of the American College of Physicians to form an organization known as the National Advisory Council on Geriatric Medical Programs. The purpose of this new group, which since that time has continued to meet at the annual meeting of the College of Physicians, was to stimulate and promote the development of geriatric education and training in the medical schools of the United States.

I have attached for your use, Senator Burdick, a copy of the council's position paper[2] and the founding members who adopted it.

Since that time, Senator Quentin Burdick was approached and at the request of the council's chairman, introduced in the Congress a bill to provide much needed Federal funding to U.S. medical schools for development of geriatric educational programs. Senator Burdick reintroduced that bill—it is S. 37—in the present Congress, and I am glad to say that we have learned that the bill was incorporated into another bill which was passed by the Congress.

The dearth of significant attention by medical schools to instruction in gerontology, the study of aging, and geriatric medicine, the clinical application of gerontology to the care of patients, has resulted in the abrogation by a significant part of the medical profession of its responsibilities to the care of older persons, especially those who are institutionalized. This was pointed out in a 1975 U.S. Senate publication entitled, "Doctors in Nursing Homes: The Shunned Responsibility."

I have had physician colleagues tell me that they do not like to see patients in nursing homes because they get depressed when they go to nursing homes. I think one reason they get depressed is because they feel inadequate at dealing with the multiple and complex medical problems of the patients in those homes because they, the doctors, they have not learned how to deal with those problems in their education and training previously.

[1] See appendix 1, item 2, page 45.
[2] Retained in committee files.

Another attitude demonstrated by some physicians is that it is not worth doing too much medically for older persons in nursing homes. This often leads to medical abandonment of elderly nursing home patients whose symptoms and signs are not adequately evaluated, with consequent increased morbidity and mortality.

The agency of the Federal Government that has fiscal control over medicare, namely the Health Care Financing Administration, even suggested at one point that one way to reduce health care costs would be to encourage older persons to accept life termination by adoption of "living wills" that would preclude medical care during the last year of their lives. This was suggested as a cost-containment mechanism.

These nihilistic attitudes of professionals and Government, in part aimed at reducing health care costs, need to be combated by those who have more positive attitudes about the value of life in older age, and who have the expertise to enhance the quantity and quality of that life.

The resent emphasis on cost containment in health care has resulted in decreased services with consequent increase in morbidity and mortality of older persons. Perhaps excess profit containment, rather than cost containment, is the needed philosophy and policy, because with cost containment the way that organizations usually work is to reduce services.

Recent public policies in the United States are, perhaps unwittingly, resulting in what we have termed "gerocide." We feel one of the proper approaches to medical inadequacies in care of the aged is more attention to education and training of physicians.

Despite being hampered by inadequate support, a number of medical schools, including the University of North Dakota, have initiated geriatric medical educational programs. In fact, the University of North Dakota School of Medicine was the first U.S. medical school to establish a required exposure of all its students to some curriculum in gerontology, although quite limited.

In 1974, utilizing partial support from a grant received from the regional medical program, the University of North Dakota worked to develop a community nursing home as a teaching resource. This activity is described in the accompanying report of the grant, Senator Burdick, that we attached to our testimony.[1]

Starting in the 1974–75 academic year, all sophomore medical students were assigned patients at the nursing home on whom they performed comprehensive documented life medical histories, physical examinations, and diagnostic formulations upon which they based diagnostic and therapeutic recommendations, which were then carefully reviewed with a faculty member trained in gerontology and geriatric medicine.

During the past academic year, the students also utilized volunteer older persons living in the community on whom these evaluations were performed. The students not infrequently discovered significant findings, and on occasion were able to uncover misdiagnoses and correct erroneous diagnoses.

After the students completed their evaluations, copies of them were sent to the patient's physician and to the nursing home to be included

[1] Retained in committee files.

in the patient's records. As a result, some of the patients had earlier needed treatment of serious medical conditions.

Senator Burdick, I have also enclosed a copy [1] of the most recent student evaluation of this teaching experience in which over 95 percent of the students said the course was valuable and should be continued, with over 50 percent of them stating it was an excellent experience. From medical students who tend to be quite critical, this represents a very encouraging evaluation.

We would now like to expand this experience and hope to implement a previous proposal to involve resident physicians in a significant geriatric experience that would have two main components:

One, a geriatric comprehensive evaluation and referral clinic that would provide multidisciplinary evaluations of older persons. These evaluations would identify problems and allow preventive intervention before patient decompensation took place. It would also serve to identify those needed services which the community should develop to help avoid unnecessary institutionalization of older persons. This evaluation and referral service could also be extended as outreach services to other communities.

Two, an enhanced geriatric inpatient experience where residents would provide comprehensive evaluation and care for patients in the teaching nursing home. We hope this will be initiated on the teaching service of our affiliated VA hospital.

We feel that more involvement of medical students, residents, and faculty in nursing homes will raise the standards and level of medical care in those homes, just as standards and levels of medical care have generally been raised in teaching hospitals.

In part, this will come about as more attention is given to careful assessment of patients and investigation of morbidity and mortality. The level of professionalism in nursing homes needs to be raised. This will require better medical record systems for nursing homes, which until now have generally had quite inadequate medical records. It will also require a mechanism to encourage and allow the performance of post mortem examinations in nursing homes so that evaluation of diagnoses and treatment can be undertaken and communicable disease will be discerned before it spreads to other older patients who generally have lower resistance to infection.

We have a positive outlook toward the importance and value of geriatric medicine and plan to continue our efforts in this developing field.

We are glad to report that the department of family medicine at the University of North Dakota has a great deal of interest in developing geriatric programs for their residents as well as the internal medicine department at the university having interest in developing educational programs for their residents. The next testimony will be from the chairman of the department of family medicine, Dr. Robin Staebler, who will describe the plans of his department for a geriatric experience with which we, in the department of internal medicine and the rest of the medical school, are desirous and willing to provide all possible assistance.

[1] Retained in committee files.

I think it is important for us to undertake these endeavors because the systems and institutions which we develop now for the aged are those in which all of us will live and die.

Senator BURDICK. Thank you, Doctor.

Now, Dr. Staebler, we will hear from you.

STATEMENT OF DR. ROBIN J. STAEBLER, CHAIRMAN, DEPARTMENT OF FAMILY MEDICINE, SCHOOL OF MEDICINE, UNIVERSITY OF NORTH DAKOTA, GRAND FORKS, N. DAK.

Dr. STAEBLER. Thank you, Senator Burdick. Thank you, Dr. Reiff.

The department of family medicine at the University of North Dakota has strongly defined its education and service goals to provide programs that will give stimulus for learning via a model of care which will provide benefit to the community.

In response to the needs of the aging community of North Dakota and in recognition of the department of family medicine's role in health care provision in the State, the dean of the University of North Dakota School of Medicine has charged the department of family medicine with the task of development and implementation of a statewide geriatric program.

The addition of the statewide geriatric program within the department of family medicine is most appropriate as we feel that our role is characterized by the very rural, ambulatory, and personal nature of the services provided by the department of family medicine.

We operate four graduate training programs in Minot, Bismarck, Fargo, and Grand Forks. In addition to our principal postgraduate training programs, we have 32 training sites located in communities outside of the metropolitan areas, thus effectively serving approximately 160,000 people in the State. Dr. Janssen in Linton is a member of our faculty at a training site in that community. Geographically these sites cover more than 45,000 square miles and provide the opportunity to meet our responsibility for appropriate training in providing health care services for the elderly.

According to recently released 1980 census figures, the citizens in this State over the age of 65 number more than 81,500, and of those 81,500 senior citizens in this State, over half of them are in the rural areas of North Dakota.

The rural nature of this State has posed a very special health care problem for our aging community. To cite one example: 44 percent of the population age 65 or over has some activity of their daily lives limited by some chronic condition. This phenomena is best explained by the very nature of the rural employment found in North Dakota. We have a high degree of manual labor with its adjacent physical risks.

To meet the special problems of the North Dakota elderly, the rural family physician must become the most educated and informed provider of health care in his or her community. In order to meet this challenge, the family physician must not only serve as a provider to the aged community but must also realize their expanded role of advocate for the patient.

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Family physicians need to utilize extended educational resources to further develop their understanding of the psychological, psychosocial, and physiological problems of the aged as they increasingly become the principal referral source in directing the citizens of a community toward the optimal utilization of human resources.

Family medicine is a rural and community integrated system. The medical care facilities outside of our metropolitan areas are overall 99 percent staffed by family physicians. And based on this community system, family medicine proposes to establish a reciprocal program of education and service, working with the existing health care system.

This program will provide an applied educational opportunity for both medical students and graduate medical students in the delivery of health care services to the aging community of rural North Dakota. An integral component of the program will be the provision of resource support by the family medicine faculty of this State, both clinically and full time, to the physicians and community service providers of rural North Dakota. This community integrated program of health care service to the elderly will provide a rich educational experience to both our family medicine graduates and undergraduates, and in correlation will reinforce and strengthen the existing community resources.

We in family medicine intend, through the educational process, to develop a sense of service and awareness in both the undergraduate and graduate students in family medicine, and make them aware of their obligation to the aging population of this State.

With nearly 62 percent of the medicare dollar currently going to long-term care facilities in this country, the impact of the rural family physician keeping individuals under his or her care functioning and active in their community a day, a week or a year longer through effective utilization of community human resources will have a very significant impact on the health care dollar.

It is important to note that the National Center for Health Statistics reports that North Dakota ranks seventh in the Nation for the total number of health care beds per 1,000 population over age 65. In this State, health care, long-term health care facilities range from $30 to $65 a day. By providing education in preventive, rehabilitative, and therapeutic skills to family physicians as they relate to the health care problems of the elderly, we can impact very strongly on the health care dollar and the dollars expended through the health care system.

If we are able to employ multidisciplined resources and encourage home visits, the utilization of community food resources and counseling centers, and support viable programs that promote the total well-being of the aged, family medicine can and will make an emphatic statement promoting health care for the aged of North Dakota.

In its determination to design a comprehensive and relevant geriatric educational program, the department of family medicine will utilize department and medical school faculty members such as Dr. Reiff, and community resource personnel such as Dr. Janssen, and individuals in our community resource centers to serve as a geriatric advisory committee to the medical schools. Advisory committee memberships will include strong consumer representation, insuring a viable priority-based program of service as well as education.

Senator Burdick, since the establishment of the first Health Manpower Training Act 12 years ago, the emphasis established by the Department of Health, Education, and Welfare, and now Health and Human Services, has been to develop primary care, and specifically family practice education in the United States.

The goals and priorities established under these training programs are focused on the development of education. With the invested support of our State and congressional representatives, we have been very fortunate to establish in this State four fine and strong residency programs, and by directing its efforts through service and education, we in family medicine hope to provide a unique resource to the rural population of this country.

Old age has often been referred to as the season of losses. With the implementation of a statewide geriatric program, we hope to provide educational resources that will lay the foundation to reduce the impact of these losses.

I am strongly urging the legislative process to give serious and directed consideration toward establishing as a priority for Federal funding, the support for education and service programs which focus on the needs of the elderly. Continuation of support for training programs is essential to the citizens of this State who realize that health manpower requirements must be met to insure a high quality of life.

Thank you.

Senator BURDICK. Thank you, Dr. Staebler.

And the last man on the panel is Dr. Fickenscher, director of rural health.

STATEMENT OF DR. KEVIN M. FICKENSCHER, DIRECTOR, OFFICE OF RURAL HEALTH, UNIVERSITY OF NORTH DAKOTA MEDICAL SCHOOL, GRAND FORKS, N. DAK.

Dr. FICKENSCHER. Thank you, Senator Burdick, for inviting me to present some of my ideas related to the health care needs of the rural elderly.

I come here today as a relatively young elder and I would like to speak to you from a perspective of having worked throughout rural North Dakota during the last 18 months.

As many of you are aware, the school of medicine at the University of North Dakota is a primary care-oriented community-integrated medical school and is committed to meeting the needs of rural North Dakota, and in particular the office of rural health was established for that purpose.

If I can quote the legislation that created the office, it stated that the office should assist the rural communities of North Dakota in developing and maintaining viable local quality primary health care services.

During the last 1½ years we have developed efforts and programs in four areas—education, research, liaison, and community assistance. And most of our efforts have been directed at helping the rural communities. As I have traveled around the State of North Dakota and worked with many different people that are living in rural areas, it has become increasingly clear that one of the major problems in delivering quality health care relates to the needs of the elderly in our State.

As Dr. Staebler pointed out, we have more than 50 percent of our elderly in the State of North Dakota living in the rural areas, and that is by the Bureau of the Census definition of less than 2,500 people. This compares to a national average of only 27 percent.

Also, if we look at all of the communities in North Dakota, we have 253 communities, of which 239 are designated as rural. As you can see, the vast majority of the communities in this State are rural.

Another aspect that needs to be considered are the needs of the rural elderly. They have different problems which require different solutions than their urban counterparts, and too often in the past much of the legislation that relates to many different aspects of health care of the elderly has related to urban-oriented approaches which are really not applicable to the needs of rural North Dakota.

Other factors are that the rural elderly often have less education, they often have more dependence on social security as a form of income, they receive less aid from their families, they suffer from more poverty, they have more chronic illness, have less access to health care, and less access to outreach types of programs.

In North Dakota we like to think of ourselves as a relatively well-off and wealthy State, but in fact many of the characteristics that represent the rural elderly, in general, apply to rural North Dakota as well.

I think that during the coming decade we are going to see a considerable amount of debate related to these issues because of the increasing cost of health care. Currently, health care represents about 9.2 percent of our entire gross national product. Furthermore, it is projected that in 1990 it will be 11.5 percent, and that is in the face of a decline in the actual growth of the gross national product. As a result, I believe that the debate will be very significant during the next 10 years.

I believe that there are several considerations that must be considered in developing health care services for the rural elderly. First, programs and services that we attempt to implement in our communities, rural communities in particular, need to be integrated into the social fabric of those rural communities to gain acceptance. You don't develop a program in a large community such as Grand Forks and then go out and lay it on a rural community. It is not as acceptable.

A second issue is that the range of services that we need to develop for the elderly differs over their lifespan. The issue is similar to developing a program in pediatrics which relates to a baby that is 2 months old versus someone who is 18 or 19. The same issue relates to the needs of the elderly, where a range of services need to be developed.

Also there are distinct advantages, I believe, in utilizing and strengthening the existing social and helping systems of rural North Dakota, rather than developing whole new systems for the needs of the elderly.

Finally, I believe that in terms of acceptance of the types of health care services in rural areas, they must have a family-oriented approach because the family is the primary support system for the elderly.

As our goal in developing health care services, we need to talk in terms of functional capacity, relief of symptoms, early detection of disease, rapid recovery, and reduction of risks.

I believe that there are five different ways that this type of program can be developed in rural North Dakota. One of them is through the

local rural hospital. Most often, the local rural hospital serves as the focal point for health care activities in a rural community. It is an accepted institution in the community and also has frequent formal contact with the elderly as patients, and informal contact through visits to friends.

The types of programs that a hospital can develop for the elderly are areas such as Dr. Janssen mentioned, and outreach education, which I believe are quite critical. Health maintenance and preventive health care are as important for the elderly as they are for younger people.

Geriatric day care hospitals are a possibility in terms of providing rehabilitation screening services as well as homemakers and aide-type programs.

Outreach screening is also important in collaboration with existing public health programs. Respite and family vacation day care programs, in-house meal programs, in addition to meals-on-wheels, are other examples.

I believe that it is important to mobilize the elderly from their homes and allow them an opportunity to go some place where they can obtain a nutritious meal, rather than to the local cafe where too often the diet is inadequate.

Finally, the hospital can provide coordination of onsite specialty services in collaboration with the local family physician by supporting his or her efforts in delivering quality health care services to the elderly.

As an example, in North Dakota, as you are aware, Senator Burdick, we have the cares project which is a very innovative and exemplary project which has provided health care services to rural areas with specialists from the rehabilitation hospital. A team of specialists perform screening of individuals. By using the same model and applying it to the health care needs of the elderly, we can provide supportive services to our local family physicians and family nurse practitioners that deliver health care to rural North Dakota.

In essence, what I am outlining is an expanded concept of home health. In addition, there are a number of other areas that we could explore related to discussions taking place in Congress. The major problem with rural hospitals, with any hospital, attempting to develop and provide these services has been the reimbursement system.

The reimbursement system places emphasis on acute rather than on chronic care. It emphasizes institutional rather than home care. In order to change those directions, the efforts of Congress in altering existing legislation as it relates to medicare, medicaid, and also third-party payers, is critical.

A second area that is critical for North Dakota is the appropriate use of our public health nurses and our family nurse practitioners. They provide a philosophy of education and health maintenance and can assist in coordinating many of these services in our rural areas. The public health nurses in particular are important to providing screening services.

However, too often in rural North Dakota, the local public health nurse is understaffed and underfunded and, in fact, there are eight

counties in rural North Dakota where no public health nurses are available whatsoever, and that is a major problem.

A third area is our senior citizen centers which provide an ideal setting for becoming involved in medical and health care outreach. They could provide health, counseling, and referral-type service programs. Screening can take place at our senior citizen centers. Educational programs can take place. The centers are an ideal and beautiful setting in which to educate and provide health education programs.

Previous testimony has referred to transportation services. I believe that this service is also quite important. Another area—which I believe is one of the most important—is the use of young elders.

If I can just take an extra minute here, I want to talk about my grandfather who lives in Makoti, N. Dak.

Grandpa John is 74 years old. He lives in a town of 139 people in rural North Dakota. Grandpa John not only serves as a part-time janitor at the local school, but he is also on the ambulance squad, and he is very committed to helping his friends who are the same age or older than he is. The use of young elders in helping their friends is critical.

In fact, the University of Minnesota has created a program called the peer counseling program, where young elders are trained to provide counseling services to their peers. Such programs are important in terms of using the resources that exist.

The types of services that the elders can provide include home visits, escort services, and bereavement counseling. They probably understand these issues more than I, as a physician, because the elders are relating to it on a very personal level.

My other grandfather was a carpenter until he was 85 years old. If his services could have been used for his friends, that would have been quite a service. There are an array of services that the young elders can become involved in for the benefit of friends and neighbors.

My final comment relates to the local family physician. I could not agree more with Dr. Butler and Dr. Reiff as it relates to geriatrics and geriatric training. We need to have more geriatricians in this country. Yet, at the same time, I recognize that in rural North Dakota the sole source of primary care is through the local family physician, and family physicians need more training in geriatrics.

The problem has been in receiving that training. Adequate support of geriatric training for geriatricians as well as for family physicians is quite critical. Family practice is a family-oriented specialty which is important in terms of health care for the elderly. Second, it is a specialty that provides continuity of care and is a part of the community, and these issues are very critical in terms of acceptance. Therefore, the ongoing support and education of the family physicians that provide health care in rural North Dakota is really quite important. In sum, I think that the health care industry is undergoing a time of stress. The next 10 years will be quite critical. The decisions we make in the next 10 years, in fact, are of importance to me because I represent that group of the population which will place the largest stress on our society. When we reach 70 years of age, we will represent 18.3 percent of the entire population. We are the ones that are stressing

the system and, therefore, we are the ones that should also become involved.

Thank you very much, Senator Burdick.

Senator BURDICK. Thank you, Doctor.

The second part of this program is going to be some questions, but before we go into that I would like to ask the reporter, are you in good shape? Do you want a 5-minute break?

OK. We will have a 5-minute recess.

[Whereupon, a short recess was taken.]

Senator BURDICK. As I stated at the opening of the hearing, this session is to delve into geriatric medicine and medicine generally for the aged people. Other members of the committee are branched out all over the United States on various other subjects, and all of this material will be brought back to the committee and analyzed.

I am saying this only because our frame of reference here should be on health care and geriatric medicine. We are not going to branch into housing or income, things of that nature, because that is being taken care of in other places, so we would like this record to be on the subject matter.

So now I am going to ask questions of the panel, and when I am through with those questions, then we will have an open meeting format. You will be able to ask questions. You can submit them in writing, or you can use the microphone there, or you can shout. That is all right, too. But after I have finished the questions, then you will have your opportunity.

This question is for Drs. Staebler and Fickenscher. I understand that the State is planning a pilot project to provide home health care in one region. How do you think family medicine and geriatric medicine could help us with this?

Dr. STAEBLER. As far as the department of family medicine is concerned, I believe we have got to get our students and our graduate students involved in the home health care process. I think as students they should be accompanying and working with our home health care providers, and I think as graduate students they have to serve as an educational resource and a professional resource to our home health care providers.

It is our intention to promote that activity at least within the educational process.

Dr. REIFF. I could not agree more, and I think that all components in medical school have to work together and collaborate in developing programs of excellence in geriatrics. Geriatrics is the kind of field where tremendous interdisciplinary collaboration has to come about or else we will fail, because it is the broadness and the breadth of the field that requires cooperation between all segments of health education.

Dr. FICKENSCHER. I can simply reiterate what Dr. Reiff and Dr. Staebler have said. I think that one of the areas that needs to develop in terms of home health care services and the appropriate use of those services is providing education for the local physicians who are involved with that process.

I also believe that there are some misunderstandings. Whether we like it or not, we must understand who is eligible and who is not

for various services, because many times there are limitations placed on the physician. Unless a family physician, providing health care in a rural community understands those issues, it becomes very difficult for him or her in assisting and entering those individuals into that system.

I think that our medical school, through the office of rural health and the departments of geriatrics and family medicine, can be involved in those areas as it relates to the local family physician.

Senator BURDICK. Dr. Butler, can you tell us what you mean by saying that aging research can save money?

Dr. BUTLER. Yes. Just to give you a sense of cost, 62 percent of every rural health dollar goes to aging, and 30 percent of the Nation's health costs are associated with aging. In many ways this is good news because it means that we have responded to the diseases, illnesses, and disabilities of the later years and their associated costs.

It is imperative that we do something to overcome these costs—now $40 billion annually for medicare and $22 billion for nursing homes—and to control them as best we can. One important approach for containing health costs is to find more effective means of diagnosis and treatment, rooted in the new knowledge gained from research. I would just like to remind us all that it was only 20 years ago that we had our last polio epidemic. And it was not too long ago that we heard the thump, thump of the iron lung, but not any more, in large part because of medical advances stemming from laboratory and clinical research.

In a sense, the nursing home is like the iron lung of geriatrics. I do not mean that we will never need nursing homes, but that it is certainly an intermediate technology. It was not so many years ago that we had tuberculosis sanitariums throughout the Nation, and now we no longer have them. So, we obviously must always make a continuing investment in new knowledge and be certain that it is applied to treat and, hopefully, abolish diseases.

One disease that we at the National Institute on Aging are most anxious to make an impact on is senility, which accounts for so many people now in American nursing homes. Another preventive disease we are focusing on is osteoporosis, which is the bone thinning that leads to so many hip fractures which again, speaking nationally, account for 8 percent of admissions into U.S. nursing homes.

Senator BURDICK. Dr. Janssen, you mentioned the value of routine health screening and health prevention techniques. I understand this senior center offers such a service. Could this be done in senior centers statewide or nationwide?

Dr. JANSSEN. Senator Burdick, when we started our screening technique, it was actually started by our hospital, and we encouraged our senior citizens to use the facilities as much as possible. It is a relatively simple procedure, as we all know, and the manner in which it is done is quite easy, really. Any qualified person, such as a registered nurse or a licensed professional nurse, can do the procedure. Often they are willing to do it voluntarily, for nothing.

As I mentioned in my speech, we were able to get a small grant so the nurses could not only do blood pressure checks but also carry out foot clinics and simple glucose determinations on our patients.

To give you an idea of the cost, it was $4,000, the price of the grant, and over 500 people are seen on a yearly basis. I think that the cost-effectiveness is quite obvious in Emmons County in that patients who have been found to have very high, high, high blood pressure or are diabetic, we are able to treat all the ones we found as an outpatient.

The comment made about 62 percent of the health care dollar going to geriatrics, you can well imagine if we can even prevent 1 hospital day by the simple screening techniques, then the cost-effectiveness should be inherently obvious to all of us that it should be done and it can be done in urban and rural centers.

Senator BURDICK. Sister Wieland, do you know how many home health agencies there are in North Dakota now and how many people does your agency serve? How many elderly do you estimate there are in North Dakota who could be served by home health who do not have access to any such service?

Sister WIELAND. There are 14 certified agencies that I know of in North Dakota, hospital based. Right now, North Dakota has a goal—the North Dakota Association of Home Health Agencies has a goal of establishment of home health agencies throughout all of North Dakota. This is within the next couple of years.

My own agency covers two counties. The average census is 65 patients that I have on the census list. Last year, we made over 4,500 visits. We have a staff of nine people which includes five professionals, two aides, and a secretary.

Some of the questions I missed.

Senator BURDICK. How do we get this type of activity in more areas in the State?

Sister WIELAND. How do we get it into more areas of the State?

Senator BURDICK. Yes.

Sister WIELAND. I think education of the public where older people do not understand some of the advantages of preventive care, and the advantages of spot checks on them, on their health, just to spot check them. Also, professional people need to be educated of the availability of home health services, and be convinced of its value.

I know physicians—some of the feedback I get from physicians is that we are in competition with clinics, which we are not. We bring people to clinics often who would not otherwise go. The hospital nurses are not aware enough of the preventive factor of home health and of what we can do. We just have to sell ourselves more.

Senator BURDICK. Thank you.

The next question is for Mr. Lundene and Mr. Tweet. If you care to expand on that last answer or answer my question more fully, if you wish, but also will you answer the following question. Do you believe that home health care needs to be greatly expanded? What has been your experience with home health care services?

Mr. TWEET. I am sorry, I do not understand your question.

Senator BURDICK. Do you agree that home health care needs to be greatly expanded and what has been your experience in that area?

Mr. TWEET. Naturally, with a larger and larger population growth in the old age group, you are going to need to expand the load of caring for these older people. I feel that the idea of the home care is excellent. I think that we are going to be realistic and realize that

we must somehow or other be able to implement what we are doing now in caring for the people with the home service.

However, my feeling is that we do not realize the hazards. We do not realize the dangers that are involved in people living in isolated farm homes, or homes without someone being there to take care of them when the time comes. I have had no experience with the home service. My experience has been entirely with skilled nursing, and I do know that when the utilization review committee at the hospital comes to the conclusion that that person needs to be moved from the hospital bed to a nursing bed, they look to the nursing home to have a bed available for their use.

I think that just about covers it.

Senator BURDICK. Henry, do you want to add to that?

Mr. LUNDENE. I would just like to add this, that the fear that my friend has about these tragedies happening in the homes, he probably does not remember that we happen to have a telephone reassurance, which is a program accepted by aging services out of title III funds. This is where the volunteers call every one of the senior citizens who are living by themselves in their homes daily, and through this avenue they can know how serious their situation is. If they answer the telephone, they are usually in pretty good shape.

As far as the health districts are concerned, the lady talks about—the sister from Rolla talks about—the health districts, and I believe that they do have health districts in the western part of the State. I may be wrong, but the eastern part of the State does not have health districts. There are no health districts east of Devil's Lake, to my knowledge, and we do need home health care so very urgently in our area.

And with my apologies to you for your time, but would it be possible—and this is something that we tried to manipulate in Walsh County through the efforts of an organization here in Grand Forks—to have a van, a health van, which would be properly staffed with the proper personnel and proper equipment. They could go out over a county or two, or more counties, and check some of these people for their blood pressure, their glaucoma, their urinalysis tests, and different things. They could take care of the people when they are out at the different senior citizen centers, and the rest homes, and these places.

We think that this would be of tremendous value if that could be established, you know, with a nominal cost. Let me say, too, that many of these senior citizens are in the low-income area, and they cannot afford to go and pay $12, $15, $16, $20 for a blood test or a blood pressure test. They need something that is—surely they want to pay something—but they cannot pay those kinds of rates.

Senator BURDICK. Well, Henry, what you are advocating is a health mobile. Would anybody on the panel care to comment on his suggestion?

Dr. REIFF. I think it is a very important and a very needed health care facility. I think it is one of the new technologies in a sense, that has to be applied to geriatrics, that Dr. Butler talked about.

Mr. LUNDENE. Thank you.

Senator BURDICK. Dr. Butler, I am very encouraged about your announcement of the teaching nursing home program. This is a major breakthrough. We have had a program like this here for some time, so I know it can work.

Do you know how large the program will be? How much interest have you had from nursing homes and medical schools already? Will the program be able to support training for health professionals as well as research in geriatric care?

This is a three-part question. Handle it as you wish.

Dr. BUTLER. Well, Senator, interest in the teaching nursing home program has been enormous. We have already received literally hundreds of phone calls and letters from nursing homes, schools of nursing, and schools of medicine, in anticipation of the announcement of the competition for this award.

What is most encouraging to me is the fact that even if we are limited by the number of such homes that we are able to fund, the private sector appears to be ready to contribute. For example, the Robert Wood Johnson Foundation, one of the largest foundations in the Nation with an interest in health, has also announced a teaching nursing home award competition, centered principally on schools of nursing.

So, while the National Institute on Aging may be able to support only one or two homes, depending upon the funding level this year, I nonetheless think that the private sector will provide some support for such an entity.

My own hope is that every one of our 126 medical schools will ultimately have such a teaching environment. It is unconscionable to think that present-day medical students can graduate without having profound personal experiences in such environments. By extension, I am referring as well to nursing students, speech pathologists, and medical social workers, among other professions.

Senator BURDICK. Thank you.

Dr. Janssen, I recently sponsored a bill to allow medicare payment for nursing home care even if the patient was not in a hospital first. If this becomes law, how do you think it is going to help?

Dr. JANSSEN. That is an excellent point. One of the problems that I face is, many of my patients will come to me and say, "I would like to come in the hospital 3 days for a rest," and I would say, "Well, why do you want to come in the hospital 3 days for a rest?" They say, "Well, my family has decided I should go to a nursing home, and the Government will pay for it if I get in the hospital for 3 days," and being a very conscientious physician I say, "No." There obviously has to be change, you know.

One thing that has to change is primary care physicians, first of all, should be reimbursed to a better degree than they are now. People such as yourselves have to use primary health care physicians more, more effectively. There is tremendous resources available to you, and your primary care physician will direct you toward them and will coordinate your care.

I think this is especially true for the elderly who are prone to not only multiple investigations which are sometimes questionable but also polypharmacy. That is also very questionable. And I think if we redirect some of our priorities and allow physicians to admit to a nursing

home where it is necessary, without going from an acute care center into it, I think that would be a tremendous step forward.

Senator BURDICK. Dr. Reiff, one of the suggestions you made to the North Dakota Governor's Council on Aging is the establishment of a geriatric evaluation and referral center. If we cannot get health professionals with geriatric training in rural areas, maybe this would be an alternative. Would you explain how this would work? How would it help doctors and nurses in rural areas?

Dr. REIFF. What we proposed at the request of the Governor's Commission on Aging several years ago was that ambulatory geriatric evaluation and referral centers be established somewhere in the State at opportune sites. These centers would allow for comprehensive and multidisciplinary evaluation of the health problems of older persons. It would be a consultant service.

One of its main uses might be in evaluating an older person who is being considered for nursing home institutionalization, to provide an assessment, and then to make a proper professional decision as to whether or not nursing home institutionalization was really the optimal method of management of the patient. If it was not, then recommendations would be made about alternatives.

The comprehensive evaluation would then be utilized in managing the patient's health problems. Even if the patient did require nursing home institutionalization, it would provide a good record and a plan on which further care and treatment could be given, or if the patient did not have to go into a nursing home, that this plan of management and this assessment would be sent to the patient's physician, and other health care providers, to allow for maintenance of the patient in the community.

This type of evaluation would also allow a recognition of the deficiencies in the community that had to be corrected so that the patient could stay in the community. It would, in a sense, pinpoint what other kinds of health care provision had to be available. We would envision also that the resources of this geriatric evaluation referral center could be provided on an outreach basis, and perhaps the traveling van that Mr. Lundene mentioned could provide a mechanism to get this type of evaluation out into the rural areas.

I think—and perhaps Dr. Staebler could speak to this—that the family practice centers that we have in various parts of the State for teaching of medical students could provide the very good base for such geriatric evaluation and referral centers.

Senator BURDICK. Dr. Staebler, would you like to enlarge on that?

Dr. STAEBLER. Yes, I would, Senator. Dr. Reiff's department and Dr. Reiff has proposed that we use our four centers for purposes like this. It is my firm conviction that we have to utilize our specialists in geriatrics and gerontology to train the young family physician to provide this type of assessment and referral service.

One of the difficulties I faced as a rural family physician was having the tools and the knowledge at my disposal to adequately make an informed judgment as to the placement and care for the elderly under my care. I have to go back to Dr. Janssen's response to your question, Senator, on financing. With 12 years of rural experience, one of the greatest problems I faced was the requirement to acutely hospitalize

someone at great expense, in order to move them into a chronic care facility. And in line with that, one of the feelings that I have on the subject is that as a family physician in a rural community, very often I had to hospitalize the elderly patients in my community, not because they really required acute hospitalization, but because they could not afford to pay for some of the support services that would have kept them out of an acute hospital.

If we could have had a homemaker come in and cook a decent meal, and provide medication, I would not have had to send them to a hospital that requires $110 a day per diem rate. I could have had a homemaker for $25 a day, and I really feel that the emphasis on reimbursement has to be totally addressed through the mechanics of the legislative process.

Dr. FICKENSCHER. Senator, if I could just add a comment here. I would like to briefly expand upon a concept that I talked about very briefly in my remarks, which was the cares project. The cares project is run through the rehabilitation hospital. Home-care specialists that work at the rehabilitation hospital travel to Dickinson on a periodic basis, I believe about every 3 or 4 months, and provide onsite consultative services to patients that are referred by their local family physicians. The purpose of the program is to take the skills that exist at the rehabilitation hospital out to rural North Dakota in order to help the family physicians provide the type of technical care not generally available in rural North Dakota.

That same concept can apply to the needs of the elderly. For example, most rural communities do not have access to occupational therapists. Many of them do not have access to physical therapists. Many of them do not have access to audiologists.

The whole list of paraprofessionals involved in health care largely work in major centers and, as a result, rural communities do not have access to those types of services, which are critical to the local family physician in delivering quality health care. By taking a team of these individuals out to work with local people, like Dr. Janssen in Linton, N. Dak., he could provide better ongoing care for the rural elderly.

Senator BURDICK. Thank you.

Our time is running short. It is 11:30. We are going to open this up to the public, and you can address your questions to the panel, but I think I have room for just one last question to you, Sister Wieland.

What about the use of specially trained nurse practitioners and physician extenders? How can geriatric nurse practitioners get into the health delivery system? Could they do more in nursing homes? Could geriatric nurse practitioners also provide much community care? Is there a role for geriatric licensed practical nurses as well as for registered nurses?

Sister WIELAND. I think the nurse practitioner in the rural area is the answer to a lot of problems that we are now experiencing. I think a nurse practitioner, working in a nursing home, would probably give better care than what the people are receiving now from the physician who visits once a month, and who does it in a harried kind of manner, because of the other responsibilities he has.

Also I can see nursing, nurse practitioners in the home health field, because of their diagnostic ability and their evaluation ability, which often a nurse does not have, as a nurse practitioner does.

The L.P.N. is being utilized very much in nursing homes now, in fact almost exclusively other than a nurse in charge. L.P.N.'s as far as working in a home-health program, I find that they do have limited services to offer because it does require a nurse to do a lot of evaluating. They have a lot of reports to submit to the physician and to the medicare, and so forth, whereas I do not find that an L.P.N. is as useful as an R.N. in this situation.

Senator BURDICK. Mr. Lundene, do you care to address this question also?

Mr. LUNDENE. Yes; I believe that if we could possibly develop such a thing as a van, then these L.P.N.'s, or anybody, or anyone who has some training so that they would be qualified personnel, would come out and make these tests, and I still think that this is important.

I feel rather out of place up here amongst all of these educated people because, after all, I have been—I am nothing but an old farmer who has suffered through the depression, and I am a victim of that depression, but I do not mind it.

But we do have these real problems, and how we are going to meet them. I hope that some of these people have the brains that can figure these things out, and personally I would sure like to help.

Senator BURDICK. Let me warn you about these old farmers, you know, I pull that a lot, about being a country lawyer, too.

Well, the time has come for your participation. If you have a question, you can submit it in writing or come to the mike, any way you want it. Direct your question to anybody on the panel and we will start off.

Sister WIELAND. I do not have a question, but I would like to submit to the hearing more—I did not have the information on hand as far as home health agencies in the State, and I would like to submit more correct information, by just getting this information for you because I do not have it with me.

Senator BURDICK. Will up to November 30 be enough time?

Sister WIELAND. Oh, yes.

Senator BURDICK. Glad to have it.[1]

STATEMENT OF RACHEL SCOTT, GRAND FORKS, N. DAK.

Ms. SCOTT. My name is Rachel Scott and my question is addressed to you, Senator Burdick. I am a gerontological nurse-educator at the University of North Dakota. I work in helping nursing students and practicing nurses to upgrade their knowledge, skills, and attitudes to provide knowledgeable and caring assistance to aged persons to manage their health, and maintain their preferred quality of life.

Nurses are by far the most numerous group of health care providers, and the group in the most frequent contact with aged persons in their homes, in their communities, and in nursing homes and hospitals. They now make and can potentially make an even greater contribution to the health education of elders, to the providing of a caring and supportive environment, and to the maintenance of health to which all speakers have referred.

[1] See appendix 1, item 1, page 43.

Many of the needs expressed here will require an increased number of nurses well-grounded in gerontologic knowledge and skills. What measures do your committee plan, Senator Burdick, to assist more nurses in undergraduate education, in graduate nursing and research, in continuing nursing education to upgrade their gerontologic nursing knowledge and skills to provide the quality of nursing service which elders clearly need and deserve?

Senator BURDICK. Well, this question that you have just asked involves a question for the Appropriations Committee. We do not go into finances and appropriations in the aging committee.

But I can say from my experience and my history, that I have always supported programs like this. But this is basically an appropriations question and all I can do is give you a guess at this time. I do not know.

STATEMENT OF ROBERT E. LEE, GRAND FORKS, N. DAK.

Mr. LEE. Mr. Chairman, my name is Robert Lee. I am a retired farmer, like Henry Lundene up there. I went through that depression, too, Henry. I am going to talk as an individual and I am also going to talk as the chairman of the North Dakota Community Action Group.

About 2 weeks ago, I got one of the shockers of my life when I heard the television say we had a flu epidemic last year, last winter, and the tragic thing of that flu epidemic was that 70,000 senior citizens died of the aftereffects of that flu epidemic. They also said that was a malpractice to the medical profession of this Nation. I thought that was a pretty strong statement, but our backsight is better than our foresight.

After I heard this statement, I communicated—there were no flu shots available to the senior citizens of the State of North Dakota unless you went to your own doctor, or you were in a hospital or a nursing home—so I communicated across the line. I am affiliated with East Grand Forks, too, in Minnesota. A lot of Norwegians over there—pretty good people, too. And they said a mobile bus was coming in on Thursday, be in a certain place on Thursday morning, certain place Thursday afternoon. If you could not afford a free flu shot—that is awfully hard to say for an exfarmer—it will cost you $4. So 2 weeks ago I got my flu shot.

I highly recommend that this State adopt a mobile medical setup and any combination that they can to take care of rural America like Minnesota is trying to do right now. That is one of my statements.

Another statement I want to go to—Henry Lundene touched on it—I think every senior citizen that is tied up at home, they should be next to a telephone in or out, and I would say our next legislature should act on that, and even on the national level, that they should be available to a telephone even though in some cases they might not be able to use it.

Thank you.

Senator BURDICK. Just a minute now.

Mr. LEE. OK.

Senator BURDICK. Which one, which member of the panel would like to respond?

Mr. LEE. Well, I did not come up here to be questioned.

Dr. BUTLER. I might just say, very much in line with Dr. Janssen's recurrent point, how important prevention is, and the tragic consequences inadequate planning for vaccinations for flu or, for that matter, pneumococcal vaccine. How sad it is not to have these vaccines readily available for all older persons.

As a matter of fact, last year this Nation had a surprising drop in life expectancy, and it appears that this drop was due largely to the unattended possibility of utilizing what we already know. It is imperative that we apply available technology to protect the lives of people of all ages and, specifically, older persons because they are particularly vulnerable to flu and pneumonia.

Mr. LEE. That is the shock I got about 2 weeks ago.

Mr. LUNDENE. May I answer Mr. Lee? At the last session of the legislature, the silver-haired legislature had passed a bill and recommended to the legislature—it was introduced that we have $1 million of additional State funds for the homemaker service—and I am sorry to say that it died for the want of constitutional majority. It only got 50 votes in the house, and it died because it did not have 51.

Senator BURDICK. I would like to tell Mr. Lee that the staff has just advised me that vaccinations for pneumonia have been included in present legislation, so it is of some help.

Mr. LEE. Too late for me now. I got mine.

Dr. REIFF. Senator Burdick, I would like to make a comment in relation to what Mr. Lundene talked about, and the information you have just given that pneumococcal vaccination now is being funded.

Dr. Janssen mentioned polypharmacy, and I think some of the people here may not know what polypharmacy is, and it is related to the point that Mr. Lee raised and funding. Polypharmacy or geriatric polypharmacy relates to the inappropriate and overuse of medication in older people. Many older people are taking unnecessary drugs or taking duplication of drugs. Geriatric polypharmacy is a very dangerous practice because taking drugs that one does not need can be dangerous, or taking too many drugs can be dangerous for older people, because they are very prone to getting side effects, toxicities, and complications.

One of the things that has contributed to it in the field that Dr. Butler is an expert in, is medicare policies regarding psychiatric care and evaluation for older people. Medicare, which is supposed to pay for or reimburse for the medical care of older persons, reimburses at 80 percent of usual and customary fees without limit for surgery, for X-rays, for diagnostic tests, and other kinds of medical care. For psychiatric evaluation and care, medicare only reimburses at 50 percent of usual customary and reasonable fees up to a limit of $250 a year.

For these days, for $250, you cannot get much more than a psychiatric consultation and perhaps a few followup visits. The result of this inadequacy of reimbursement by medicare has resulted in older people being treated for emotional disorders, not with psychotherapy, care, and human contact that they require, but being treated by drugs for emotional disorders.

Not that the appropriate use of psychopharmacologic agents, drugs, and treatment in emotional disorders does not have a place, but it is

being overutilized with too many tranquilizers and antidepressants, rather than, perhaps, looking into the emotional cause and trying to correct the condition.

I venture to say—and this is testimony that I have given at other places—that hundreds of thousands of older persons in the United States each year are being overdosed and inappropriately treated with drugs because of the medicare policy of restricting reimbursement for psychiatric evaluation and care.

What the Government in a sense is telling us is that they do not think older people are worth spending money on for psychiatric evaluation and care, and I think an alerted public needs to do something about this.

Senator BURDICK. All right. The next question.

STATEMENT OF KATHERINE S. PFEIFLE, R.N., DIRECTOR, HOME HEALTH CARE SERVICE DEPARTMENT, UNITED HOSPITAL, GRAND FORKS, N. DAK.

Ms. PFEIFLE. Senator Burdick, my name is Kathy Pfeifle. I am director of home health care services at United Hospital, Grand Forks, and I am also chairman of the legislative committee of the North Dakota Association for Home Health Services.

Instead of a question, I would like to provide some basic information, if I may. In response to the certified home health providers in the State of North Dakota, there are presently 16 certified providers by the Department of Health and Human Services. These home health agencies are scattered throughout the State of North Dakota.

There are various types. There are some which are proprietary and others which are nonprofit. Some of the health agencies are community based and some are hospital based and some are freestanding.

In response to the question about the potential home health patients in the State of North Dakota, the national statistics—and I believe that they do apply for North Dakota except on the high side—3 to 7 percent of all hospital discharges are potential home health candidates.

At United Hospital home health care services, we presently serve 7.2 percent of hospital discharges. I would also like to reply in regard to how services may become started or get started in the State of North Dakota, and also nationwide, because there is also a problem throughout our country.

Education, as Sister Joanne stated, is very, very appropriate. We need a lot of education, not only to the public, but to physicians, nurses, all providers of health services. There also needs to be something taken into consideration in the area of startup expense. It is very, very costly for home health agencies to get started.

There has been Federal grant funding in the past to fund new home health agencies if they are serving an area where there is an indigent population, and also a high percentage of elderly and minorities, but that funding has since been eliminated and is no longer there. It is very difficult for a rural provider to get started, especially a small hospital or small county health department.

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We also need to take a look at a change in our reimbursement system federally. Congress needs to study this very much. We need to take a look at, involving our private sector, and when I am talking about the private sector, I am talking about the commercial insurance companies in funding home care. The benefits are limited. They are improving, but they still are limited.

We need to look at program planning, logically, systematically planning home health agencies and involving all health care, not only home health providers but all providers of health care in general, to coordinate services so that we do not end up duplicating each other, but providing and working together.

I would like to comment on Mr. Tweet's comment about people requiring 24-hour care. Very few people that are in their home environments do require 24-hour care. I think we need to provide them with the ancillary support systems such as Mr. Lundene mentioned, the telephone reassurance program. It is an excellent program.

Home care—one comment about the cost-effectiveness of home care when it is used appropriately. Home care can be used inappropriately as well. But if it is used appropriately it can be cost-effective.

I would like to quote some of the statistics from our own agency. For one patient, taking a look at a group of patients over the length of a year, patients who usually are on service have a length of stay of 90 days. Their average cost per day is $8.04, and they have a total cost for their length of stay of $965. It is a lot less expensive than institutionalization.

Thank you.

[See appendix 1, item 5, page 55, for additional statement of Ms. Pfeifle.]

Senator BURDICK. Thank you.

Proceed, please, with the next question.

STATEMENT OF DAVID P. COLE, GRAND FORKS, N. DAK.

Mr. COLE. Senator Burdick, a friend of mine in this audience has told me that if I do not make this statement I am going to age appreciably in the next—in the immediate future.

Senator BURDICK. Well, hurry up.

Mr. COLE. My name is David Cole. I am a full-time graduate student here at the university. I am in a group classified as older than average. I recently celebrated my 60th birthday.

I am very much impressed by, and I have learned a great deal from, the presentations made by these panelists. Most of them have referred to the need of continuing and additional support, financial support for the kind of things that they are advocating. I am very much in favor of that.

It is my understanding that you and your colleagues in Congress are going to be taking a very critical vote within the next few days, if I am correct, in regard to items requested by the Department of Defense, and indeed our President. May I really humbly suggest that you vote against the funding of such items as the MX and the B–1, and that you lead in the effort to divert the funds that this country has, to support the kind of things that have been so eloquently described here at this meeting.

Thank you very much.

STATEMENT OF KEVIN P. COLER, GRAND FORKS, N. DAK.

Mr. COLER. Senator Burdick, my name is Kevin Coler and I am an employee of the State social service board. The question has been raised concerning home health aide and homemaker service and I would like to address that question. I recently received the statistics for the homemaker-home health aide services which are provided by county social services, which are different from the statistics that were previously submitted.

For the fiscal year 1979–80, there were 3,745 recipients in the State, which was an increase of 32 percent over the last fiscal year. The projection for the fiscal year 1980–81 is that there will be over 4,000 recipients of the homemaker-home health aide service.

Homemaker service is provided by county social services in 53 counties in the State of North Dakota, and homemaker-home health aide is provided in 38 counties within the State of North Dakota. I just wanted to give you some of the statistics for homemaker and home health aide services provided by social service boards.

The last time there was a cost study done on homemaker-home health aide services was in 1974, and the statistics from that show a cost saving of approximately $62,000, and I would assume that, even though it is an old statistic, that again would carry through if you were doing the same kind of cost study today.

Thank you.

Senator BURDICK. Thank you.

Before this hearing started, a lady from Belcourt Reservation talked to me. Do you wish to make a statement now or do you want to submit it, your testimony in writing?

Ms. CROWS HEART. I am going to submit it in writing.[1]

Senator BURDICK. Fine. Fine.

STATEMENT OF TRACY POTTER, GRAND FORKS, N. DAK.

Mr. POTTER. Senator, thank you. My name is Tracy Potter. I worked for 3 years as the life and health insurance analyst for the North Dakota Insurance Department, and in that employ I came into contact with many insurance agents and hundreds and perhaps thousands of elderly people who had complaints about their insurance and the way that health care is financed.

In 1965, medicare was a bold step for the Congress to take. It made sense at that time to cover part of the population and cover them for part of their health care bills, but we have seen now that that experiment was, while not a failure, is not completely a success.

Senior citizens today are terrorized by the health care bills that they are still compelled to pay, the parts that are not covered by medicare, and this terror comes to their door in the form of insurance salesmen who use scare tactics to terrify the elderly into purchasing insurance that they do not need, and that has very little value for them.

For example, insurance companies are making a killing in this State and nationally, selling packages of supplemental insurance to the elderly that return only 30 or 40 cents in benefits to health care pro-

[1] See appendix 3, page 74.

viders, while they are paying out 50 percent of their premium dollars in commissions to agents, companies that are actually taking in premium dollars and paying more out in commissions to their agents than they pay back to the elderly.

My only question would be, when are we going to get these parasites out of the system?

Senator BURDICK. Just a minute, I want to reply to Mr. Potter.

Congress passed a law in 1980 that set standards for such insurance in the States. Are they adequate?

Mr. POTTER. I do not believe they are adequate, sir, and they are only voluntary. They are not a mandatory guideline. They do not have to be followed.

Senator BURDICK. I think you raised a good point, and I would appreciate it if you send us a letter to show us how inadequate they are.

Mr. POTTER. I would be glad to. Thank you.

Dr. REIFF. Senator Burdick, I would like to make a comment on that, what Mr. Potter just raised, which I think is very important.

The Federal Government has been concerned over fraud and abuse of the additional insurance that is required by medicare beneficiaries, but would not the proper solution be to improve the medicare reimbursement so you would not need the additional insurance?

STATEMENT OF DR. BEN G. GUSTAFSON, GRAND FORKS, N. DAK., CHAIRMAN, NORTH DAKOTA GOVERNOR'S COMMITTEE ON AGING

Dr. GUSTAFSON. Senator Burdick, members of the panel, I am Ben Gustafson, chairman, North Dakota's Governor's Committee on Aging.

In all of this discussion, probably the most needy people that we have in the State of North Dakota have not been mentioned. We talk about 80,000 people in North Dakota over the age of 65, of which approximately 50,000 are single elderly women, and of these single elderly women, there is going to be on the order of 15,000 to 20,000 who are trying to exist on less than a poverty-level income.

I believe that Dr. Butler made some comments on this last night at the Chester Fritz Auditorium that could be repeated at this time. As I have attended meetings over the United States in the last year, this is the group of people for which we should have the most concern about at this time.

STATEMENT OF JUDY L. DE MERS, GRAND FORKS, N. DAK., DIRECTOR, FAMILY NURSE PRACTITIONER PROGRAM, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE

Ms. DEMERS. Senator Burdick, members of the panel, my name is Judy DeMers, and I am the director of the family nurse practitioner program at the University of North Dakota School of Medicine. I have submitted written testimony [1] and, because of the time factor I will not reiterate the things that are in that testimony. However, I do have a question for Dr. Butler.

[1] See appendix 1, item 6, page 58.

In listening to you last night and again this morning describe the program for training for geriatric medicine, it seems to me a tremendous program that has been needed for a long time I am very supportive of it. The concept of team training, however, was not mentioned in the context of the program. It concerns me a great deal that the people who are out in the forefront in rural North Dakota providing primary care to the elderly, the nurse practitioners, the physician assistants, the registered nurses, the licensed practical nurses, and others, are not included within the training program for geriatric medicine.

The physicians, obviously, spend time with the patients. If you look at around-the-clock services, however, they are provided by registered nurses and licensed practical nurses. I am very concerned that these professionals also be included in the training so that they can do a better job of providing care. I am wondering if there is provision for them.

Dr. BUTLER. I share your concern and agree with you completely. The National Institute on Aging does not have authority to train nurses, so I can only speak in terms of where we do have legislative authority. However, we have been working very closely with a variety of nursing leaders in the United States in the hope that the very point that you are making can be reflected in the support provided elsewhere by appropriate agencies.

I did mention in passing the fact that the Robert Wood Johnson Foundation is providing funds for the teaching nursing home, which centers on the school of nursing, and also the National Institute on Aging Teaching Nursing Home Award which not only includes schools of medicine, but also schools of nursing. I am in total sympathy with you. I am not, however, the decisionmaker that can decide how and where such funding should derive.

Ms. DEMERS. I also would like to encourage Drs. Reiff, Staebler, and Fickenscher to think about adopting the team approach in the programs that they have used. I am confident they will, having worked with them significantly in the past.

Thank you.

Dr. REIFF. I would just like to add to Ms. DeMers that the use of allied health professionals, nurse practitioners, and physicians, is essential to have successful geriatric education and for geriatric care. You cannot run a decent program in geriatrics without the use of the allied health professionals, and in fact the departments of family practice throughout the Nation recognize it and have incorporated allied health professionals very strongly in all their efforts.

Dr. STAEBLER. And I agree with you completely, Dr. Reiff. As a matter of fact, all four centers at the present time are collaborating with the school of nursing and the health practitioners division of the department of community health to support the concept of cotraining.

Senator BURDICK. I understand that we must vacate this room at 12 o'clock. It is going to be used, and I was going to have one more comment, so, Henry, you have got it.

Mr. LUNDENE. I am a living image. I married an R.N.

Dr. BUTLER. Very quickly, picking up on Dr. Gustafson's comments about the plight of older women, I would be happy to submit for the

record, if you would like, a factsheet that repeats the material which Dr. Gustafson referred to last night, namely the details of the poverty and the very real problems experienced by older women in the United States.

Senator BURDICK. I would be very glad to have it and make it part of the record.[1]

Before we disband here this morning, I want to thank the panelists, because some of them have come a long way and they are using their time to help us find the facts so that we can do something about this very important problem. So to all the panelists, my thanks, and to all of you who came, certainly we are glad that you came here, too.

So with that, the meeting will be adjourned.

[Whereupon, at 12 noon, the hearing was adjourned.]

[1] See appendix 1, item 3, page 46.

APPENDIXES

Appendix 1

MATERIAL SUBMITTED BY WITNESSES

ITEM 1. LETTER AND ENCLOSURES FROM SISTER JOANNE WIELAND, ROLLA, N. DAK., ADMINISTRATOR, PRAIRIELAND HOME HEALTH AGENCY, ROLETTE AND TOWNER COUNTIES, N. DAK., TO KATHLEEN M. DEIGNAN, PROFESSIONAL STAFF MEMBER, SENATE SPECIAL COMMITTEE ON AGING, DATED NOVEMBER 24, 1981

DEAR KATHY: Enclosed is the information I was to submit to Senator Burdick, to be included as part of the report on the hearing proceedings on rural health care, which was held on November 14, 1981, at Grand Forks, N. Dak.

It was a very informative day, and I was impressed with Senator Burdick's concern for the elderly.

Thank you for the assistance you gave me at the hearing. It was helpful to be informed beforehand on the procedure of the day.

Cordially,

SISTER JOANNE WIELAND.

Enclosures.

EXCERPTS OF PRAIRIELAND HOME HEALTH AGENCY EVALUATION REPORT, JUNE 1, 1980 TO MAY 31, 1981

The year June 1, 1980 to May 31, 1981, has been a year of growth for Prairieland Home Health Agency. Total client visits for a 12-month period have increased from 1,933 in 1979–80, to 4,844 in 1980–81. This is an increase of approximately 40 percent in home health visits. The expansion program has also developed successfully in Towner County, where 1,257 client visits were made during the grant year. The terminal progress report submitted in September 1981, to the Health and Human Services Department of the Federal Government may be referred to for a more detailed report of the expansion program.

The Prairieland Home Health Agency was surveyed by the North Dakota Department of Health in July 1980, and the agency received certification for another year. In September 1980, the agency, as a department of the Rolla Community Hospital, was surveyed by the Joint Commission on Accreditation of Hospitals. Accreditation was received for 2 years without any recommendations for the home health department.

The Prairieland Home Health Agency has remained financially sound in the past year. All areas of home health care revenue have exceeded budget projections with the exception of L.P.N., respiratory thereapy, and physical therapy services.

Eighty-eight clients were admitted to P.H.H.A. during the year. Listed below is admission by diagnosis information:

Diabetes	10
Cancer	10
Cerebral vascular accidents and trans-ischemic attacks	8
Congestive heart failure	8
Degenerative joint disease	6
Post-surgery	6
Hypertension	6
Injuries and fractures	5
Cardiac dysrhythmias	3
Osteoporosis	2
Chronic obstructive lung disease	3
Emphysema	2
Hydrocephalus	2
Parkinsons	2

Decubitus ulcer	1
Diverticulitis with rupture	1
Acute pancreatitis	1
Central nervous system disability due to cord injury	1
Asthma	1
Dementia	1
Pneumoconiosis	1
Pulmonary hyperplasia	1
Multiple sclerosis	1
Guillian Barre syndrome	1
Ulcerative colitis	1
Recurrent thrombophlebitis	1
Post-operative depression	1
Placenta previa	1
Pulmonary embolism	1
Total admissions	88

During the year the census gradually increased from 42 to 65 clients, with an average census of 59.

Month	Census	Admissions	Discharges
June 1980	42	9	3
July 1980	52	14	4
August 1980	56	7	3
September 1980	54	6	8
October 1980	60	10	4
November 1980	62	4	2
December 1980	58	4	8
January 1981	66	13	5
February 1981	67	6	5
March 1981	64	3	6
April 1981	63	6	7
May 1981	65	6	4
Total		88	59

Sources of referrals of clients admitted to PHHA

Self or family	17
Physicians	60
Hospitals	3
Nursing homes	1
Social services	2
Other	5
Total referrals	88

There were 88 admissions in the two-county area. The physician continues to be the main source of referral, as can be seen from the admission information as charted above.

BREAKDOWN OF VISITS MADE BY MONTH AND SERVICE DURING THE YEAR

	1980							1981				
Home visits	June	July	August	September	October	November	December	January	February	March	April	May
Skilled nursing care (registered nurse, licensed practical nurse)	205	262	256	228	267	288	303	306	306	328	351	323
Home health aide	83	92	82	98	100	86	99	105	75	71	89	113
Physical therapy	8	29	24	12	12	10	10	8	18	11	7	14
Respiratory care	0	3	2	0	2	1	1	1	0	2	7	0
Dietary		1						1				
Recreational therapy												1
Social services	6	9	9	2							3	
Evaluation visits	12	16	10	9	9	4	11	16	9	7	7	4
Total	314	412	383	349	390	389	424	437	408	419	464	455
Admissions	9	14	7	6	10	4	4	13	6	3	6	6
Discharges	3	4	3	8	4	2	8	5	5	6	7	4
Census	42	52	56	54	60	62	58	66	67	64	63	65

During this year there were 59 discharges. Reasons for discharges are charted below:

Reasons for discharge	Rolette County	Towner County	Both counties
Condition improved; teaching completed, client or client's family taking responsibility for care	11	20	31
Client admitted to nursing home	6	7	13
Client expired	8	2	10
Client moved out of area	1	1	2
Client refused services	3	0	3
Total discharges	29	30	59

A total of 134 assessment visits were made during the 12 month period. Below is a statistical report of assessment visits of possible clients who were not admitted to home health services, and reasons for their not being admitted.

Reasons for nonadmission	Rolette County	Towner County	Total
No need for registered nurse or physical therapist skilled service	8	11	19
Evaluated for another type of care	1	3	4
Doctor refused admission to home health	10	0	10
Clients refused home health care	5	2	7
Other reason	6	0	6
Evaluations without admission	30	16	46

Increasing physician support and understanding is necessary for greater utilization of the program. This is especially true in Rolette County, as can be noted from the above statistical information.

INFORMATION ON HOME HEALTH SERVICES IN THE STATE OF NORTH DAKOTA

There are 15 home health agencies in the State: Nine hospital based home health agencies, five community health based, and one for-profit agency.

There are three in the process of applying for licenses and certification by the State health department. Two of these are community health based, and one is hospital based.

If more information on home health services in the State is needed, you may contact: Marie Brennan, R.N., health facilities consultant, North Dakota State Health Department, Bismarck, N. Dak. 58501. Telephone: 701-224-2352.

ITEM 2. FACTSHEET ON RURAL ELDERLY, SUBMITTED BY DR. ROBERT N. BUTLER, DIRECTOR, NATIONAL INSTITUTE ON AGING

PREPARED FOR DELEGATES TO THE 1981 WHITE HOUSE CONFERENCE ON AGING

(1) Over a third of Nation's elders (8.7 million) live in rural areas. They constitute (a) 37 percent of the total elderly population of 25 million, (b) 12 percent of the total rural population, and (c) 4 percent of the total U.S. population.

(2) Women comprise 57 percent (5 million) of the rural elderly population. Most rural elderly women are age 72 years and older. While the highest concentrations of elderly women are in rural villages and towns, elderly men predominate on farms and in open country.

(3) The rural elderly population is overwhelmingly white (92 percent). Blacks comprise 7 percent, but proportionately more elderly blacks live in rural areas than elderly whites.

(4) Most of the rural elderly live in families—84 percent of the men and 58 percent of the women. Women are far more likely to live alone or with nonrelated persons than are men.

(5) Virtually all men in rural elderly families serve as the family head. Of the rural elderly women living in families, 70 percent are wives of the family head, and 15 percent are heads themselves. Some 15 percent of rural elderly women are other family members, chiefly parents or in-laws of family heads who are under age 65.

(6) Many rural elderly households occupy structures at least 40 years old. Of the 5.5 million elderly households in nonmetropolitan areas in 1976, about half (2.7 million) were in structures built in 1939 or earlier. Some 21,000 of these households had no electricity, and 249,000 did not have an indoor toilet.

(7) Homeownership is high among rural elderly persons. About 80 percent of rural elderly households own or are buying their homes, versus 67 percent of urban elderly households.

(8) Nearly 4 out of 10 rural elderly couples in 1979 had small incomes—below the minimum adequate budget of the Bureau of Labor Statistics (costing $7,703). Almost half of rural elders living alone—77 percent of whom were women—had income below the corresponding budget for single persons ($4,622).

(9) Rural elders have a higher poverty rate than older Americans in general. In 1970, the rate of official poverty was 19 percent among the rural elders, and 14 percent for older Americans in general. Blacks in the rural elderly population had a poverty rate of 46 percent.

(10) Almost 21 percent of rural elderly men are in the work force, compared to 18 percent of elderly men in the suburbs and central cities. About 8.4 percent of elderly women in urban and in rural areas are in the work force.

(11) Rural elders tend to report more activity limitation than urban elders. About 75 percent of elders say they need to reduce their everyday activities for health reasons, compared to 40 percent of urban elders.

(12) Serious health problems are widespread in the rural elderly population. More than half the rural elderly (56 percent) say they have serious health problems, compared to 24 percent of the urban elderly. While 47 percent of urban elders rate themselves in good health, only 15 percent of rural elders do.

(13) Rural elders tend to have significantly more cardiovascular disease and slightly more respiratory, sense organ, endocrine, urinary, and psychiatric problems than have urban elders.

(14) Rural areas generally are considered short of health-care professionals. They have 12 percent of the Nation's physicians, 18 percent of its nurses, and 14 percent of its pharmacists.

(15) Rural areas tend to be short of health-care facilities. About half the Nation's counties—principally rural counties—have no home health agency. Rural hospitals tend to be small, understaffed, and limited in variety of services.

(16) Transportation to help the elderly reach health facilities is scarce. About one-third of the rural elderly lack a car or access to one.

(17) Many rural elders apparently do not receive services they need. Although data are limited, studies in Kentucky and Oregon showed that about half or more of the rural elderly did not receive services they needed. Urban elders had an 8 times greater chance of getting day care than rural elders, and a 3 times greater chance of getting homemaker help, according to one study.

(18) Trouble in getting and paying for health services is fairly common. In a 1976 Kentucky survey, 31 percent of persons age 60 and older reported difficulty in getting to a doctor, 21 percent in reaching a hospital, and 21 percent in paying medical bills. Three-quarters of respondents indicated either a strong interest (33 percent) or a moderate interest (42 percent) in the establishment of a special facility for the aged in the county.

(19) Explanations for the inadequacy of rural supportive services include insufficient demand and tax base in thinly inhabited areas, their comparatively low wages or salaries for recruiting trained personnel, and certain characteristics of the rural elderly, such as, (a) greater reliance on kin systems; (b) values that emphasize independence and abhorrence of "charity"; and (c) lack of information about services.

ITEM 3. FACTSHEET ON OLDER WOMEN, SUBMITTED BY DR. ROBERT N. BUTLER, DIRECTOR, NATIONAL INSTITUTE ON AGING

PREPARED FOR DELEGATES TO THE 1981 WHITE HOUSE CONFERENCE ON AGING

(1) Women generally outlive men. Life expectancy at birth: women, 77.1 years; men, 69.3. At age 65: women, 18.3 years; men, 13.9.

(2) The future aged population will grow; the women's segment faster than the men's.

[Figures in millions, rounded]

	1980	2000	2020	2040
Total elderly population	25	32	45	55
Women	15	19	27	33
Ratio of women per 100 men	147:100	150:100	144:100	152:100

(3) The female population age 75 to 84 will grow 58 percent and that age 85 plus will grow 101 percent in the 1976–2050 period.

(4) More than half of all elderly women are widows. After age 75, the widowhood rate is almost 70 percent. Widows outnumber widowers 5 to 1. If the husband is 5 years younger than the wife, the chances of widowhood are 50 percent; if both are the same age, 67 percent; if the husband is 5 years older than the wife, 75 percent.

(5) Elderly women are more likely than men to live alone or with nonrelatives. In 1977, 6.5 million elderly persons lived alone, 5.1 million being women. The trend to living alone has grown, faster for women than for men.

(6) As a group, older women are poorer than older men. In 1977, median income was $4,300 ($81 a week), if the woman lived in housing she owned, and $3,700 ($71 a week), if she lived in rented housing.

(7) Women and minorities are heavily overrepresented among the aged poor.

[Percent of aged poor]

	Total	White	Black	Hispanic origin
Men	10.0	8.3	26.7	20.9
Women	16.7	14.7	38.9	25.1
Both	13.9	12.1	33.9	23.1

(8) States with the highest concentrations of elderly persons, and therefore of elderly women, are Florida, Pennsylvania, Rhode Island, Arkansas, Missouri, Oklahoma, Iowa, Kansas, Nebraska, and South Dakota.

(9) Women constitute 750,000 of the 1.1 million persons in nursing homes. They are likely to be widowed, divorced, or never married, and to be poor and receiving medicaid benefits. Major reasons for admission are incontinence, immobility, and senile dementia.

(10) Half of elderly nonmarried women have very low retirement income.

[1978 figures, in percent]

Retirement income	Couples	Single men	Single woman
Under $1,000		1	1
$1,000 to $1,999	1	5	6
$2,000 to $2,999	2	14	21
$3,000 to $3,999	5	21	23
$4,000 to $4,999	6	13	14
$5,000 to $5,999	8	9	9
$6,000 to $6,999	9	7	7
$7,000 to $9,999	23	15	10
$10,000 to $14,999	23	9	7
$15,000 to $19,999	10	2	2
$20,000 to $24,999	4	1	1
$25,000 or more	8	3	1

(11) Diseases found more often in older women than in older men are: Osteoporosis (bone thinning that makes fractures more likely); of the estimated 15 million persons with osteoporosis, at least 75 percent are women. Arthritis; about 10.6 million older Americans, mostly women, have arthritis of one type or another. Hypertension (especially in minority women). Diabetes. Senile macular degeneration (a leading cause of blindness).

(12) Elimination of major cardiovascular-renal diseases would add 12.2 years of life for white women aged 65 and older (versus 9.5 for white men), and 15.1 years for black women (versus 10.4 for black men). Women would gain about the same number of years as men if major diseases of other kinds could be eliminated.

(13) Chronic diseases afflict women more than men after age 45 to 50, but men have higher rates of fatal diseases. Women are more apt than men to perceive symptoms and to seek care.

(14) The trend of less and less participation in the work force is expected to continue for elderly women and men. However, women age 45 to 64 have been participating more. This probably means more financial security in later life. It probably means, too, that they will be less available to serve elderly relatives.

(15) Private pensions are less likely to cover women in full-time employment than they are to cover men. Of 59.7 million full-time wage and salary workers in 1979, nearly 30 million were covered by retirement plans. Some 55 percent of male workers were covered, compared to 40 percent of female workers. This was an increase from 37 percent in 1972.

(16) Women reaching ages 70 to 74 today tend to have had few children, their fertile years having coincided with the Great Depression. But women reaching the ages 65 to 69 through the year 2000 will tend to have had more, since they are the mothers of the post-World War II "baby boom."

ITEM 4. LETTER AND ENCLOSURE FROM DR. KEVIN M. FICKENSCHER, DIRECTOR, OFFICE OF RURAL HEALTH, UNIVERSITY OF NORTH DAKOTA MEDICAL SCHOOL, GRAND FORKS, N. DAK., TO ANN HUMPHREY, AIDE TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 24, 1981

DEAR ANN: Enclosed is the copy of my full presentation to the Consortium on Gerontology that I would like to have entered as my formal testimony for the field hearings. If you have any questions, please feel free to contact me.

I appreciated the opportunity of working with you on the hearings. Hopefully, we will have an opportunity to work together on other areas again in the near future. As always with kindest regards, I am,

Sincerely,

KEVIN FICKENSCHER.

Enclosure.

RURAL HEALTH CARE NEEDS IN NORTH DAKOTA FOR THE ELDERLY

Aging is perhaps one of the most important and greatest sociological and cultural phenomenon facing the Nation. In preparing for my presentation it also became equally clear that the decisions that we, as a society will make over the next decade related to aging and the elderly, will impact most significantly on the "baby boom" generation. In recent months the entire issue of aging and elders has taken on an increasing sense of urgency with the recent debates on the future of social security.

The aging of America is placing multiple demands upon our society and impacting on many facets of our society beyond health care. The aging of America is influencing health care at a tremendous rate and is anticipated to continue to impact on health care and health care costs in the foreseeable future. The magnitude of the health care issue related to the elderly is permeating all facets of our communities, particularly rural communities in North Dakota. It is an issue that is demanding innovations since health care costs are escalating dramatically. Yet, the problem of the aging of America defies a single solution. As an example, health care costs and retirement income are two very different—yet interrelated—issues affecting the well-being of older citizens.

In preparing for the presentation it became clear that there were several recurring themes, including: "overlap," "fragmentation," and "duplication of services" which not only relate to the elderly but also to the health care system as a whole. We are entering the "era of limits" and a "decade of debate" on the allocation of resources. It will be important for us as individuals to participate

in balancing the wants and desires with the capabilities of our society and government to respond to the needs of the elderly.

Before proceeding, I believe it is important to recognize that there is considerable debate on the definitions of the issues as it relates to health care for the elderly. For example, many studies on the health care of the elderly differentiate between "young" elders (age 65 to 74 years) and the "old" elders (greater than 75 years). The usual indicators of health status are often of little utility in discussing the health care needs of the elderly. Morbidity and mortality are inevitable outcomes in caring for the elderly; therefore, they do not represent good indicators. Other measurements are often more nebulous but at the same time perhaps represent better indicators of the health care outcome for the elderly. These include such areas as: Level of disability, satisfaction and comfort, and level of independence in functioning. These factors would appear to have a higher relative importance in discussing the health care outcomes of the elderly and yet at the same time defy quantification.

During the last decade we have witnessed major inflationary elements in our society that have affected costs in many different ways. For example, the export price of crude oil has increased dramatically over the past 5 years with an additional 53 percent increase projected for the period 1981–84. The average American expends 25 percent of his budget on energy whereas the elderly average about 40 percent. Second, medical care consumed 9.2 percent of the gross national product (GNP) in 1980, with the percent projected to be 10.2 percent in 1982. The general inflationary elements of our national economy leads to an erosion of real income for the elderly who are most often dependent upon fixed incomes. For the period 1973–78 the Consumer Price Index increased by 47 percent; natural gas, by 108 percent; home heating oil, by 83 percent; and electricity, by 66 percent.

The Consumer Price Index allows for cost-of-living increases in social security (since 1972), and supplemental security income (since 1974). Therefore, some protection is afforded to the elderly but a dependence upon pensions leaves the elders unprotected. For example, if we assume a 6 percent inflation over the next several years the real dollar purchasing power of a pension will be one-half its value in 1992 compared to 1980.

Another important factor is the fact that the projected growth in the GNP is very important to overall expenditures in our society. The growth in GNP will have significant ramifications on the capability of society to finance and fiscally respond during the coming decade. According to Data Resources, Inc., an independent economic firm, and the Department of Labor, the rate of growth for the GNP during the coming decade will decline. Overall for the period of 1981–90 the rate of growth will only represent 6.8 percent. As the GNP pie grows more slowly it will become increasingly difficult for the Government to take the responsibility of meeting the needs of the elderly. This is particularly important, since in 1980, income security and health benefits represented 25 percent of the entire Federal budget.

The Congressional Budget Office has estimated that the cost of health care will increase dramatically over the next decade. In 1980, the cost of health care represented $245 billion, and it is projected that in 1985, the cost will represent $440 billion, and in 1990, $760 billion. The 1990 figure represents 11.5 percent of the projected gross national product. Furthermore, one of the major contributors to the growth in the cost of the overall health care budget will be long-term care, which is projected to represent 10 percent of the entire health care budget in 1990.

It seems likely that increased pressure will be placed on local and State governments and the private sector to pick up the difference for the cost of health care related to all areas since the slowing in growth of the gross national product will not be able to withstand the economic pressures without deficit spending. Since deficit spending is not a goal of the current administration, we can anticipate that over the next several years this pressure will mount substantially. The growth in the aging population may translate into a heavier tax burden on the working population since Government expenditures directed toward the young can only be decreased slightly. An alternative approach would be to provide changes in the existing retirement system that provide incentives for later retirement. However, such changes do not alter the actual health care costs to be incurred by our society. They do allow for greater contribution to the overall Federal budget with more tax dollars.

The growth in the age 65-plus population will increase dramatically over the next 40 years. In 1980, this group represented 11.2 percent; in 1990, 12.2 percent; and in 2030, 18.3 percent, which is projected to be the peak for this age group. An examination of the growth in the elderly would reveal that the fastest growing segment of the greater than age 65 population would be in the age 85-plus category; second, the age 75 to 84 years category. These two population groups consume considerably more health care services than the age 65 to 74 years category.

With an increasing number of elderly the cost of health care services will no doubt expand considerably over the next 40 years. In 1977, the per capita expenditures for health care for age 65-plus were $1,745 per person, and for those individuals less than age 65, $646 per person.

Even though the average expenditure for health care for those individuals greater than age 65 is dramatically higher than the average, a closer examination of all health care expenditures for the elderly reveals that the elders utilization of services is slightly below the general population. Health care, physician services, dental services, professional services, pharmaceuticals, eyeglasses, and prosthetics, as well as other areas, as a percentage of all costs are utilized to a lesser extent by the elderly than their younger counterparts. The major exception is in the area of long-term care which represents 25 percent of all expenditures for individuals age 65 years and greater, versus 6.7 percent in the general population.

The long-term care issue is of particular importance in discussing the needs of the elderly. In the period 1965 to 1978, the cost of nursing home care increased by 16.9 percent per year and is projected to consume 10 percent of all health care expenditures by 1990 ($76 billion). Long-term care represents the fastest growing component of all personal health care expenditures and yet, institutionalization represents one of society's most negative images of aging. It is uprooting and confusing (i.e., transfer trauma), disruptive of the continuity in the elders' life when they are least able to cope and adapt, and it enhances dependency.

Five percent of all individuals greater than age 65 reside in long-term care facilities at the present time with 20 to 30 percent of the elderly residing in such facilities at some point in their later years. However, studies have indicated that at least 50 percent of the elderly that are currently institutionalized could live more independently if alternatives were available with 15 to 20 percent of these individuals living at home with appropriate support services.

The three leading causes of admission to the long-term care facility includes senile dementia which affects 3 to 4 million people, incontinence, and immobility. One of the major contributors to immobility is the hip fracture (195,000 per year) with most of the fractures occurring in post-menopausal women. It is estimated that the cost of each fracture is $10,000. Significant cost savings could be realized with the reduction in this cause of morbidity.

Other factors which designate the elderly "at-risk" for institutionalization include: (1) An age greater than 70 years; (2) living alone; (3) dementia; (4) recently bereaved; (5) recent discharge from the hospital or immobilization; (6) being female; (7) multiple medical problems; (8) socially isolated or depressed; and, (9) no support from relatives due to distance.

Note, that except for being greater than age 70 years and being female that all of the factors which were just listed are amenable to some type of intervention.

Another factor which is important in terms of long-term care facilities is the source of revenues. Currently out-of-pocket contributions to long-term care represents 50 percent—medicaid, 48 percent; and medicare, 2 percent. The Reconciliation Act of 1981 provided for changes in the Federal medicaid contribution formula which will have an important impact on State expenditures. The current Federal contribution is greater than 50 percent of all expenditures in the medicaid budget. In fiscal year 1982, the medicaid formula will be decreased by 3 percent; in fiscal year 1983, 4 percent; and fiscal year 1984, 4.5 percent.

Another factor that is important in relating to the health care needs of the elderly are the medical problems. Many of the medical issues affecting the elderly are little understood by physicans and others involved in their care. Gary Kart in his book "Aging and Health" has outlined the complexity of the problems related to caring for the medical needs of the elderly:

"The sensory changes affect visions, hearing, and taste. The lens of the eye loses its ability to focus causing farsightedness, furthermore, the lens gradually becomes clouded by cataracts which reduces the amount of light that can pass to the retina. The end result is dim vision. This can be compensated for by

wearing reading glasses and increasing home lighting. The ear loses its ability to pick up high levels of sound. Problems of communication can result from the inability to hear certain vowel and consonant sounds. Speaking to older adults in lower tones can help compensate for this period. The sense of taste becomes diminished probably because of a decrease in number of taste buds. This often leads to poor nutrition because food lacks flavor. Increased seasoning of food is often helpful in correcting this. There is a decrease in the number of neurons causing slowing of voluntary muscular control. This is one reason why older people need to function at a slower rate. This knowledge can help people accept changes in their previous performance. Skin changes include a decrease in the subcutaneous fat which leads to decreased body temperature control and a decrease in sebaceous glands leading to dry, itchy skin. To deal with these changes people must protect themselves from extremes of temperature and use more creams to prevent dry skin * * *"

Studies have documented the fact that the older patient receives less time with the physician despite the multiplicity of medical problems. Also the elderly suffer from more potentiating and iatrogenic problems by taking multiple medications for multiple conditions. Often the medical conditions of the elderly are protracted and the multiplying effect of medical problems creates difficulties in appropriately handling these problems. Finally, due to the chronicity of the medical problems of the elderly, the physician often finds caring for the elderly less satisfying than that of other patients which "tend to get well."

In addition to the many factors which I have discussed related to the elderly in general, there are other important issues that impact on the rural elderly. There are identifiable differences between the urban and rural elderly. The urban elders tend to be older, single, foreign born, more educated, more dependent upon pensions as a source of income (70 percent), receive more aid from their families (10 percent); and suffer from less poverty. The rural elderly tend to be male, married, permanent residents of their community, less educated, less dependent upon pensions (30 percent), receiving less aid from their families (2.5 percent), and have a higher degree of poverty.

Poverty is a particular problem in the age 75 and greater age group. Often savings have been depleted by the time the elderly reach this age. With the cost of medical and health care, savings have often been depleted very quickly after the illness of a spouse which leaves the partner with major financial difficulties. If we look more closely at the issue of poverty, it becomes increasingly clear that the single elderly are the major individuals who suffer. For the period 1959 to 1978, poverty among those individuals age 65 and greater, declined from 35 to 14 percent. However, in 1979, the percentage of individuals age 65 and greater that were designated as poverty, increased to 15 percent. Hopefully, this represents a temporary reversal rather than a permanent trend.

In addition to the other factors listed above, the rural elderly have other important characteristics that differentiate them from their urban counterparts. They have a greater number of restricted days, and yet receive fewer visits to physicians; they have access to fewer available outreach services and social welfare resources; they suffer from more chronic illness; they live in more substandard housing; and have less access to transportation due to geographic barriers, distance, unpaved roads, unavailability, and cost. As an example of the problems with transportation related to cost, a study was conducted in Arkansas. It showed that for urban areas the average cost per ride was $1.72, whereas for the rural elderly the cost of a ride was $6.04. Finally, rural populations in general do not obtain preventive and health maintenance services due to time, distance, access, and education. Coupling this particular problem with many of the factors referred to in the preceding discussion and the rural elderly are at a significant loss as it relates to health care.

In defining rural areas, I have used the Bureau of the Census definition which indicates that a rural area is any population group less than 2,500 people. If we use that criteria, 239 of the 250 towns and cities in the State of North Dakota are designated as rural. The 14 major communities of the State represent approximately 45 percent; therefore, 55 percent of the entire population in the State of North Dakota reside in rural areas as defined by the Bureau of Census. North Dakota has 652,695 people spread over 70,665 square miles. The density of the population ranges from 47.6 people per square mile in Cass County, to one person per square mile in Billings County. This creates unique problems for the delivery of health care services in rural North Dakota in terms of access to serv-

ices and the capability of rural communities to support services due to sparsity. This is particularly important for the rural elderly since there is an absolute lack of sufficient manpower and services throughout the State. For example, 21 percent of the State's physicians provide health care to 55 percent of the people. Overall, North Dakota is ranked 43d in the United States for available health manpower; 29 of our 53 counties are designated as "health manpower shortage areas," with 21 of the 29 in the "01/02" category, which are designated as "critical" health manpower shortage areas.

In the last census one of the largest net gains for the rural and nonmetropolitan areas was in the age 65-plus group. The growth in the rural elderly was in areas that are not adjacent to standard metropolitan statistical areas (SMSA). The rural elderly overall increased by 4.2 percent, whereas the urban elderly only increased by 2.9 percent. Nationally, 27 percent of all elderly 65-plus years of age live in rural areas as defined by the Bureau of the Census. In North Dakota, 20 counties have populations greater than 13 percent for the age 65-plus population (range: 13.2 to 17.3 percent). Furthermore, if we look at the internal demographics of the counties it would reveal that the rural communities in the State of North Dakota approach 30-plus percent elderly. The recent statistics in the State indicate that in 1970, the elderly represented 12.6 percent with an apparent decline to 12.3 percent in 1980. The decline is apparent and not real because of the dramatic growth in energy development in western North Dakota. Many of the rural counties in that area of the State have increased dramatically in population and the population influx has primarily been with young workers in the oil and coal areas.

Other factors which are of particular importance to the rural elderly in North Dakota include the fact that eight counties in the State are without the services of a public health nurse. In addition, those counties that do have these services are often underfunded and understaffed. Another major factor in the State of North Dakota is the culture of our relatively homogeneous rural elderly population. These people pride themselves on independence and the "prairie survival" philosophy which creates difficulties in acceptability of public service programs and serve as a barrier to participation.

So the question remains: What can be done for rural North Dakota in caring for the elderly? There are several issues which are of importance in addressing this particular question. First, there is considerable cultural and geographic diversity within and between the small towns and communities in North Dakota. Most of the rural elderly in our small towns are lifelong residents of the area and have often retired in an adjacent community. As an example, my Grandpa John, who lives in Makoti, N. Dak., is a retired farmer and 74 years old. He recently finished the wheat harvest, provides local veterinary services for small animals, works as a janitor at the local school, is a member of the local ambulance squad, and yet—is skeptical of outsiders and outside programs. Therefore, it becomes increasingly important to develop programs for the elderly as part of the community rather than through outside intervention strategies.

Second, community services for the aged must reflect the changing needs of advancing age over the 65-plus year lifespan. To plan for all programs for the elderly as if the age 65-plus group was one population does not consider the very important differences in the age group and is an oversimplification. Therefore, a range of services is needed that addresses the needs of the young elders in relationship to the old elders.

Third, myths of the rural elderly need to be reversed. The "country living" depicted in the Walton's is not reality in rural North Dakota. Many studies indicate that the myth of the integrated, extended family present in rural areas is simply untrue. Furthermore, the myth of wealth is also not entirely true. The rural elderly have a greater dependence on social security as a sole source of income without pensions, savings, and aid from families.

Fourth, there are significant advantages to strengthening existing social and helping systems (horizontal intervention) rather than creating whole new systems (vertical support) for the rural elderly. Sandy Hanson, a medical social worker at the Montana State University, has described three common rural helping systems which have varying degrees of success.

The primary helping system for the elderly include the family and neighbors. The system operates out of concern for and familiarity with the people and families involved. It is a voluntary and informal system which serves as a rich resource for the rural community. In recent years this source of support for the

elderly has been stressed due to the increasing number of women in the job market. Due to this phenomenon no one is at home to provide care for elders in need of assistance.

The secondary system is also an informal system. It includes institutions, agencies, or programs that have as their focus something other than the direct "helping" of rural elderly but that are involved with people. Examples include churches, schools, and clubs. This system is stable and easily identifiable and assistance is readily accepted by the elders.

The tertiary system is a more formal system. It is composed of agencies, institutions, and programs whose major responsibilities are the delivery of helping services. Eligibility is clearly defined and the system employs professional individuals responsible for particular services. The rural elders often view the system as suspect because it is often not part of the community. Many of them believe that the types of services offered through this system are reserved for crisis situations. In addition, headquarters are often distant from the community and therefore, not integrated into the social fabric of the community.

Research indicates that the rural elder services could be enhanced by supporting—not supplanting—the established and less formal helping systems existing rural areas. Of primary importance in developing any system for the elders is to involve the social network of elders. It promotes efficiency and acceptability. Yet, the overwhelming majority of human service programs for the elderly are often developed and delivered for these individuals as if they function in a social vacuum. Therefore, in order to have the greatest impact it would seem appropriate to affect the entire social network of the rural elderly.

As an approach to the health care delivery for elderly in rural North Dakota, the primary goal is "to maintain the independent functioning of rural elderly." The area of health maintenance is particularly important including such areas as: Attention to functional capacity (rehabilitation), relief of symptoms (access to medical care), early detection of disease (screening), rapid recovery from acute illnesses (after-care); and reduction of risks (ongoing assistance). If we examine the existing social and health care services in rural North Dakota, I believe, that several acceptable and ongoing programs can serve as a framework for providing health care services to the rural elders. These include: The rural hospital, the local public health nurse, senior citizens centers, young elders, and the local family physician.

Like the health care system in general, the rural hospital remains illness- and crisis-oriented providing only acute care services. Yet the hospital is often the focal point for the community and represents an acceptable "local" institution which serves the people as part of the community. Often because of the frequency of health problems and the chronicity of these problems, the elderly frequently have formal (as a patient) and informal (visiting friends) interaction with the hospital. In fact, the viability of the rural hospital, I believe, is dependent upon the adaptability, productivity, and creativity related to health care services that increasingly relate to the needs of the rural elderly. The small, rural hospital could potentially function in a variety of nontraditional areas outside the four walls of the institution that fit in quite well with the continuance of health care services for the elderly. These include:

(1) Outreach education for the young elders through senior citizen centers and social clubs. For example, educational programs in hypertension, stroke, nutrition, diabetes, and other areas which require an allocation of hospital staff time would be important services for the elderly.

(2) Organized geriatric day care hospitals with emphasis on continuing functioning, screening, and rehabilitation to assist the elderly in coping with independent and family living are quite important. These types of services are especially critical in the face of increased physical and mental infirmity as one progresses in age.

(3) Coordination of outreach screening with the local public health programs. These types of services could be provided in local housing units and through existing local community clubs.

(4) Develop respite and family vacation care programs for the purpose of supporting existing home care by the nuclear family.

(5) In-house meal programs for elders so they are not forced to eat inadequate meals or do not get out and remain immobile or confined to their homes.

(6) Coordination of onsite specialty services directed to the needs of the elderly. In particular, the areas of needs that cannot be met with the local re-

sources, services, or professionals should be of particular focus of this type of program. For example, expansion of a very successful and needed concept in the State of North Dakota—as the CARES Project—should be considered. The CARES Project is specifically directed at rehabilitation services. A similar project using such professionals as psychiatrists, nutritionists, physical therapists, pharmacists, occupational therapists, optometrists, audiologists, and others would be quite helpful in assisting the local family physician to deliver adequate health care services to the elderly. The focus of these types of programs could be health education and, in particular, a family nurse practitioner could serve as a team leader of such an effort. These types of services could serve as an adjunct to the efforts of the local family physician in his or her efforts to provide quality health care services for the elderly.

In essence, many of the roles that I have outlined for the hospital involve varying degrees of home health care services. These services are desperately needed in rural North Dakota where approximately 55 percent of the population resides and yet these same areas are the ones that are most often without access to these types of services. One of the primary difficulties in the past has been strict Federal requirements and standards in terms of the type, level, and degree of professionals required under regulations to become eligible for reimbursement.

Four major functions are included in these types of home health care services including: Household tasks, social and community services, personal and medical maintenance, and human services. Because of its position in relation to the community, the small rural hospital has the capability of addressing the major issues that contribute to underutilization of home care services. These include such areas as lack of credibility, unavailability, unaccessibility, lack of coordination, and lack of a family-oriented approach.

I believe that home health and home care services will receive increasing attention during the coming decade. For example, the Reconciliation Act of 1981 designated that medicaid can now pay for services that are designed to keep elders more functional in the home. Robert Packwood (R-Oregon) and Bill Bradley (D-New Jersey) are cosponsoring legislation for a 10-State demonstration project on home health care services. Their proposal would consolidate health care options for all patients who might benefit from long-term care in the home, establish methods for identifying elderly in need, test alternative methods of payment for home health care services, provide that all patients pay a portion of the cost for these services, and place all noninstitutional, long-term care services under one title rather than through multiple categorical programs.

Other proposals that have been considered in Congress include tax credits for taking parents and relatives into the home, altering the supplemental security income payment system so as not to penalize the elder for living with his/her family, altering the eligibility of home health care services so that they are not denied if an individual is living with the family, providing low-interest loans to alter the family's house if space is not available for the elder, and modifying existing Internal Revenue Service Codes to allow deductions for certain services provided to the elders as part of home health care services.

However, the major problem to the provision of these and other services by the rural hospital is the existing reimbursement system which is more comprehensive for acute rather than chronic services and institutional- rather than home-oriented types of health care delivery.

The second area that I believe is quite important includes the role of the public health nurse. The public health nurse or family nurse practitioner provides a philosophy of preventive health care. In addition these practitioners often provide leadership by their established linkages and interface with community resources for the elderly. One of the biases that I have is that public health nurses should be trained as family nurse practitioners. This would tend to facilitate the outreach of medical services which are of major need of the elderly beyond the 4 years of the hospital and the clinic. Currently, the public health nurse functions in a relatively independent fashion from the local hospital and family physician which often creates problems in terms of coordination of care. Furthermore, it is my impression that with the public health nurse being outside of the traditional services network of health care that they are often not utilized by local health professionals. Basing the public health nurse at the hospital or clinic would, I believe, greatly facilitate the concept of ongoing care and coordination.

A third major area where activities can be generated is in the senior citizen centers. Most often these centers are viewed as "social clubs" offering little but cards, parties, and occasional outings for the elders. Yet a significant amount of funding has been invested in constructing or renovating these facilities for the rural elderly. Beyond the social functions of the senior citizens centers, these centers offer an ideal setting for health and medical outreach. Mill levy support of these centers in the past was for bricks and mortar. However, much of these funds could be used for service programs in line with the needs of the elderly, including counseling and referral services, screening and education, and transportation.

A very important fourth area of potential increased activity is the use of "young" elders. The University of Minnesota has developed a peer counseling program for training elders to provide a variety of outreach services in their community. The types of services include home visits, escort services, bereavement counseling, recreational services, home repair services, and telephone lifelines.

The final area that I think needs to receive increasing emphasis is the role of the family practitioner. The benefits of the family physician to the care of the elderly are several. They include: (1) Serving as the primary source of local medical care in rural North Dakota; (2) a specialty that is "family-oriented" from the outset which is critical in terms of acceptance and utilization of other services as described previously; (3) providing continuity of care of in-services; (4) acceptance by the rural elderly as a local service; and (5) the use of the local family physician does not create another layer of manpower.

However, the family physician needs ongoing support and further education in the health and medical care needs of the elderly. Such support could be provided by a "CARES" type project or through team-oriented care programs. The continuing education of the physician could be incorporated into onsite consultative-type programs.

I would like to provide one final comment. Much more research is needed into clinical and nonclinical areas as it relates to the elderly. Most of the research has been urban in orientation and the comparative needs of the rural versus urban aged need to be more clearly delineated to define the implications of service delivery. We need to clarify the perceived needs and actual services provided for rural elderly. We also need to more aggressively translate the research that has been performed into functional program design.

I have offered several themes today. These include:

(1) The era of limits and a decade of debate are upon us. The economics of the elderly will not allow the future to be a replication of the past.

(2) The issue of health care in rural areas directed at the elderly is multidimensional and defies a single solution.

(3) Outreach is critical.

(4) Use of local, existing, and acceptable family-oriented resources will be important regardless of the type or level of services provided to the rural elderly.

(5) Continuity of care and service are essential with coordination.

(6) The use of the interdisciplinary or team approach is to be strongly encouraged and adapted to the local needs.

(7) Prevention applies to the elderly as much—if not more so—as it does to other population cohorts; and

(8) The appropriate use and education of the family physician in rural North Dakota will be instrumental in facilitating coordination of health care services for the rural elderly.

In sum, the health care industry is currently under great stress and historically when industries undergo stress, dramatic changes occur in relatively short periods of time. This then is the time for the innovator. We must put in place solutions that place emphasis on local institutions and community strengths while drawing on resources that are available outside the local communities.

Thank you.

ITEM 5. ADDITIONAL STATEMENT OF KATHERINE S. PFEIFLE, R.N., DIRECTOR, HOME HEALTH CARE SERVICE DEPARTMENT, UNITED HOSPITAL, GRAND FORKS, N. DAK.

On November 14, 1981, I was able to present limited testimony at the U.S. Senate Special Committee on Aging field hearing, Grand Forks, N. Dak., in the

time permitted. Therefore, I would like to expand on that testimony and provide you with more specific information.

I am director of the home health care service department at the United Hospital, Grand Forks, N. Dak., a member of the North Dakota Association for Home Health Services, serving on its governing board, and am a past president of the association. The North Dakota Association for Home Health Services is an association of home health care providers and others interested in promoting home health services in North Dakota. The membership is comprised of all federally certified and licensed home health agencies in North Dakota. Certified agencies are in compliance with the Department of Health and Human Services Federal regulations and may receive reimbursement by medicare and medicaid. To date, North Dakota has 16 certified and licensed providers currently operational and providing home care to the residents of our State. Also, at this time, there has been interest expressed by potential providers desiring to establish or expand home health services within the State. Licensed and certified home health agencies in North Dakota are comprised of not only one type. The providers are nonprofit, community-based, for example, city/county health departments, nonprofit, hospital-based, and freestanding proprietary agencies. These providers serve a variety of geographic areas. Some serve multicounty areas, for example, one community-based provider serves a seven-county area, others serve single counties, and still others serve only one city. No one way of providing home health services is the right or better way as the purpose of each agency is to serve patients requiring home care to meet the health needs of the HHA's service area.

The State of North Dakota has seen a profound growth of home health services since 1977. In 1977, only seven certified providers were in operation serving 13 counties. Today, 16 providers are actively providing care in 33 counties. This is significant and points out the extreme need to provide home care to North Dakota citizens. To deal with the response from the public and private sectors demand for information and statistical data, the North Dakota Association for Home Health Services has taken a step forward and is beginning a method of compiling uniform statistical data on a statewide basis. The aim of the project is to compile data on each patient provided services by any agency in North Dakota. This data will be utilized not only internally by agencies but externally on a State and national level to inform the health care industry, legislators, and the public as to the population served, the cost efficiency of home care, and of the value home care has to users in those making decisions as to reimbursement of home health services. One reason that I am addressing this at this time is that should you, your staff, or any other Congressman wish to evaluate home care in North Dakota, this information of sound uniform statistical data will be available to you. North Dakota is the first State in the United States to develop such a uniform method of reporting and, therefore, this allows us to have many advantages in informing others of our services. Even though North Dakota has noted such a significant growth in the provision of home health services statewide, we still have a deficiency in the number of home health agencies providing home care. Not all residents of our State have the ability to receive home care services when needed by them. Some of the problems relate to the ruralness of our area and State, and others come down to the problem of financial resources.

As I mentioned in my testimony at the hearing, 3 to 7 percent of all hospital discharges are potential candidates for receiving home health services and for those people who live in areas without home health services there are times no services are available and these people will be without. Senator Burdick, there are counties in North Dakota that do not even have available to them a county health nurse. Therefore, the residents of those counties are not served at all. The largest barrier to starting a home health agency is startup funding. Many small hospitals, county and city health departments, and individuals do not have the resources in which to invest in a home health agency. Another barrier in the startup of a home health agency is that of a delay in receiving reimbursement from third-party payers. The concern over this issue lies with the time factor involved in acquiring a provider number and provider status due to the delay of the onsite certification survey visit performed in our State by the North Dakota State Department of Health, Division of Health Facilities, who represent the Department of Health and Human Services for the purpose of the survey. The implication of this issue is great when one considers that reimbursement for services is delayed 4 to 6 months pending acquisition of provider status. This

causes not only an obstacle to the billing and collection department, but affects the budgetary needs of any home health program. Startup costs are great and no revenue is generated. This causes a financial hardship. I am concerned for all new providers of home health care in the State of North Dakota, who are just beginning services and who experience this.

As previously mentioned, it is very difficult for a small hospital and/or city or county health department, or other individuals, who require money to develop a home health agency let alone receive no reimbursement for 4 to 6 months. As you are aware, there is no Federal funding for startup expenses for establishment of a home health agency at this time. I would like to now clarify why I quote 4 to 6 months as a time factor of delay in billing in reimbursement. This is due to the Department of Health and Human Services taking approximately 2 to 2½ months to issue a provider number to a home health agency. This occurs in conjunction with the onsite survey taking place 2 to 3 months after the beginning of operation. Therefore, constituting a 4- to 6-month time delay. This in itself, is a form of penalizing new home health providers. Our concern as individuals and as a State/Nation should be to encourage the development of home health programs instead of hindering the provision of such services to the citizens of North Dakota/United States. In the area of reimbursement, Senator Burdick, I would also like to see a change come about. This should be looked at very closely. I feel that we should be looking at prospective reimbursement versus the present system of retrospective reimbursement which also has caused difficulty for operating home health agencies in the area of retroactive denials of patient care and claims. More should be done in our country to involve the private sector/commercial insurance carriers to reimburse for home care. Hospitals should take a closer look at discharge planning, providing more community outreach services, encouraging physicians to utilize home health services, and to decrease the length of stay in hospitals and also in nursing homes.

As I mentioned in my testimony on November 14, 1981, home care can be a cost-effective means of providing care to the patient and family in the appropriate place and at the appropriate time. Should you require statistical data in this regard, please do not hesitate to contact me. Home health agencies provide a variety of services that are available to all ages and patients with varying diagnoses. The services usually offered by home health agencies include: Registered nurse services; home health aide services; therapy services, such as occupational therapy and physical therapy; hospices; medical social work services; assistance with obtaining durable medical equipment and supplies; laboratory tests; and also other consultative type services. Consultating-type services that are utilized by home health agencies include, for example, dietetic and respiratory therapy consultations. At the present time, there is no reimbursement for a registered dietician and certified respiratory therapy technician to provide home visits to patients in their own homes. These services are needed by patients who can continue to reside in their own homes and if these services were available the benefit would be immense to the patients.

Advantages to home care include:

(1) Reduces the length and cost of hospitalization by making early discharge possible.

(2) Prevent hospital admissions through cost-efficient home health care visits.

(3) Allows to increase hospital bed efficiency and improve utilization.

(4) Allows the patient to receive care and extensive coverage of their physician.

(5) Provides skilled nursing and/or therapy to patients in their homes.

(6) May prevent admissions through nursing homes when the appropriate place of treatment is the home environment.

In summary, Senator Burdick, I urge you to consider carefully any pending legislation regarding home health care and its reimbursement. I ask that you contact me should you require any information relating to home health care either in Grand Forks, N. Dak., or for the entire State of North Dakota. Your support of home health care services will be greatly appreciated, not only by those of us who are providers of home health care, but by those residents of our State which we serve. Should you have any questions or concerns regarding this correspondence, please do not hesitate to contact me.

Thank you.

ITEM 6. STATEMENT OF JUDY L. DE MERS, GRAND FORKS, N. DAK., DIRECTOR, FAMILY NURSE PRACTITIONER PROGRAM, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE

Thank you for the opportunity to testify in relation to rural health care delivery for the elderly. The topic is of concern to me both from a professional and from a personal perspective. I recognize that it is a vast and complex subject covering not only health and medical care directly; but, involving the variable facets of the social, economic, political, and psychological aspects of life. All of these factors intertwine and impinge on the individual's health status. Because of the need to be brief and concise today and due to the presence and testimony of the expert witnesses which have preceded me, I will limit my comments to ones from my own professional perspective. Although limited in this respect, one should not interpret my testimony as narrow. I fully support a system and team approach which integrates and coordinates contributions from health care providers, from support service providers, and from the consumers of services themselves including the patient, other elderly, family, friends, and community members and groups.

I have directed the family nurse practitioner program in the department of community medicine, University of North Dakota School of Medicine for the past 5 years. For the 6 years immediately prior to that time, I worked in two different physician assistant training programs one at the University of North Dakota and one elsewhere. Given my 11 years of experience in physician extender education programs, I feel qualified to describe both the contributions that these two professionals can make toward improved health care for the elderly and to the barriers that the nurse practitioner, physician assistant, and the employing physician or health care facility face in trying to accomplish the goal of effective and efficient health delivery for the aging population.

It is my belief that the most personal, comprehensive, and economical way to deliver services to the elderly is through the utilization of a primary health care team. Approximately 90 percent of all needed care can be provided through such an approach according to current estimates. The medical leader of such a team legally and traditionally is the physician. Physician services, however, can be greatly augmented, expanded, and diversified through the addition and utilization of a nurse practitioner or physician assistant as a team member.

These clinicians are prepared to work collaboratively with physicians in diagnosing and managing the common problems of primary care. The nurse practitioner or physician assistant is prepared, through protocols developed mutually with the supervising physician, to manage the patient with a chronic, stable illness on an ongoing basis. Examples of diagnoses in this category include, but are not limited to, such common problems of the elderly as hypertension, chronic obstructive pulmonary disease, diabetes mellitus, arthritis, congestive heart failure, obesity, and depression. The preparation in the UND program, as elsewhere places emphasis not only on the physical signs and symptoms of illness; but on prevention and health promotion as well. The family and other support systems are viewed as integral to the recovery, maintenance, or acceptance processes and these individuals are involved actively in the care provided and in the decisionmaking in relation to the care. The UND program also places emphasis on the geriatric client throughout its educational program.

In addition to the obvious role of working side by side with the physician in the ambulatory care setting, the nurse practitioner and the physician assistant are and should continue to be utilized extensively in other settings where health care is delivered to the elderly. Hospitals, skilled nursing facilities (SNF's), and intermediate care facilities (ICF's) constitute institutional settings where utilization is appropriate. Home visits and community-based settings such as senior citizens centers and housing complexes for the elderly are included in other types of appropriate settings for delivery of health care to the elderly. Finally, the importance of both one-to-one patient education and community educational efforts cannot be underestimated.

A summary of the benefits of nurse practitioner and physician assistant participation in delivery of services to the elderly include:

(1) Education of NP's and PA's can be accomplished in the relatively short time period of 1 to 2 years as compared to 7 years or longer for the physician. The overall costs of medical education are decreased, therefore, and the availability of primary health care services can be increased at a faster rate.

(2) The education of NP's and PA's is directed to the assessment and management of the common primary care problems—which are experienced by large numbers of the elderly. Many already also receive specialized training in geriatric medicine.

(3) The education of NP's and PA's emphasizes health maintenance and health promotion as well as a team approach to delivery of services. This is helpful in preventing problems before they occur; and, therefore reducing costs—both monetary and in terms of disability.

(4) Available physician services can be expanded significantly by the employment of a NP or PA; and the maldistribution problem, therefore, can be solved partially.

(5) The services delivered by M.D.–NP/PA team are complementary, one to the other. For instance, the physician can reallocate his/her time and energies to treating those patients who require the expertise of a physician while the NP/PA can provide more of the routine services.

(6) Communication between the staffs of health care institutions and the physician's office often improve significantly with the addition of a NP/PA to the primary care team. The staffs utilize the NP/PA as a "bridge." Minor problems, therefore, are often identified and subsequent action taken before they become major ones. Again, this is helpful in preventing problems and reducing costs.

(7) Communications with immediate family and relatives also improves.

(8) Studies have demonstrated high patient satisfaction and lower malpractice incidence in practices employing NP's and PA's.

The major barrier to effective utilization of the nurse practitioner and physician assistant in delivery of health care services to the elderly is that of reimbursement policy. Three aspects must be considered if a reimbursement policy is to be established to meet the health care needs of the rural elderly:

(1) Although home health care services are authorized under both medicare and medicaid, together these programs provide minimal funding for noninstitutional service. Expansion is needed.

(2) State discretionary policy in relation to medicaid in terms of eligibility, scope and duration of benefits, reimbursement, standards of care, and utilization review has resulted in a wide disparity among States in terms of long-term care services. State discretionary policy, additionally, has affected services of NP's and PA's under the Rural Health Clinics Act of 1977 (Public Law 95-210). North Dakota, for instance, has not certified one rural health clinic under these provisions. The burden should not be borne entirely by Federal funds, but the Federal Government should take on the responsibility to identify and remove the gross inequities in services and eligibility created by the great variation across the States.

(3) Nurse practitioners and physician assistants cannot be reimbursed under either medicare or medicaid for services provided in institutional settings. I believe that this is particularly harmful to the care of patients in skilled nursing facilities (SNF's) and intermediate care facilities (ICF's). The majority of these patients are the elderly.

In 1980, the Health Care Financing Administration of the Department of Health and Human Services proposed general revision of the current regulations for SNF and ICF participation in medicare and medicaid. Among the suggested changes were two which would have provided for the sensible and pragmatic utilization of the NP and PA in these settings:

(1) Utilization of an alternative model for medical direction in these facilities using physician-directed services of nurse practitioners and physician assistants; and

(2) Substitution of physician extenders for physicians on the required visit schedule (given a collaborative relationship between the physician of record and the NP/PA).

Although neither of these proposed changes were instituted, I remain enthusiastically in support of both. I feel that both the physician and the physician extender would benefit from these changes. Most importantly, however, the patient would be the greatest beneficiary.

I thank you, again, for the opportunity to express my views on these most important issues.

Appendix 2

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER FROM KARLA R. SPITZER, IMPLEMENTATION ASSOCIATE, NORTH DAKOTA STATE DEPARTMENT OF HEALTH, BISMARCK, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 27, 1981

DEAR SENATOR BURDICK: In response to your letter of November 6, 1981, the North Dakota State Department of Health is developing a program entitled "The Community Health Project." Briefly, the intent of the community health project is to develop a comprehensive preprimary/primary and community health promotion program for the State. The project would seek to develop and expand volunteer emergency medical services and self-care groups in an attempt to address some of the problems of access in the very rural areas of the State.

A major component of this project would be to develop self-care projects and community health education for the elderly. This component is being developed in response to objective A6 of the State health plan which is to develop alternative methods of providing the services required by the elderly population of North Dakota. Objective A6 was developed in recognition of the fact that with adequate social and health services, a greater proportion of the elderly could maintain a relatively independent lifestyle and vastly improve the quality of their lives.

At present, we are making preliminary inquiries into two grants. One, a request for proposals from the Northwest Area Foundation, would be directed at health education with the development of a demonstration project to test the desirability of providing all levels of services within a single geographically integrated system in order to provide continuity of care and to facilitate the appropriate and the timely placement of individuals in settings which allow them the greatest independence possible.

The second, a grant proposal to the Kellogg Foundation, would be an attempt to provide comprehensive health education on a statewide basis in conjunction with volunteer emergency services.

Thank you for your opportunity to respond to the 1981 Health Professions Act from the perspective of how we are implementing goals and objectives of the North Dakota State Health Plan. Should you have any further questions, please do not hesitate to contact me.

Sincerely,

KARLA R. SPITZER.

ITEM 2. LETTER FROM LARRY BREWSTER, ACSW, ADMINISTRATOR, SOCIAL SERVICE BOARD OF NORTH DAKOTA, BISMARCK, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED DECEMBER 1, 1981

DEAR SENATOR BURDICK: Thank you for your letter of November 6, 1981, inviting me to attend your public hearing on November 14, in Grand Forks on "Rural Health Care for the Elderly: New Paths for the Future," and your request for input. Because I was unable to provide testimony at the hearing, I am submitting this written testimony.

We are all concerned with the costs of health care. In the United States, we spend billions of dollars a year buying the health services we receive, it is being predicted that we soon will be spending double that amount.

There are many facets to this issue, but the one which is of most concern at this point is the cost of health care for the aged. This care is provided basically to older people in hospitals, "swing beds," nursing homes, by home health agencies, and by other medically oriented programs.

There are many unmet needs among the elderly which can put increased pressure on the health care delivery system. As we know, the population age 65 years and over is increasing in numbers. This aging phenomenon is attributed to the reduced birth rate and increased longevity. Especially dramatic is the rise in the numbers and proportions of people age 75 and over—an age at which individuals are more likely to be ill than those age 65 to 74, and an age at which most of the illnesses are chronic in nature. While these situations are noteworthy, there are deeper pressures which affect the elderly more directly. Retirement or loss of a supporter or companion are events which leave many elderly people with inadequate resources and make them dependent on their children or others. Yet, taking into account the affects of inflation, mobility may make the children less likely to live near their aging parents, than in the past. Moreover, in families where both husband and wife work, there is less time to provide for elderly and often frail parents. As a result, more and more pressure will be put on society to meet these and other needs of our growing elderly population. We need to be aware that health issues entail more than just the need for medical attention.

The enactment of medicare and medicaid in 1965 marked a significant expansion of Government's involvement in the development, financing, administration, and monitoring of nursing home services. With the certification of hospitals and nursing homes as "providers of services," the general public and the Federal Government were of the opinion that the problems of health care for the aged were solved.

What we presently have is a service delivery system for the elderly that has an orientation toward institutional care, an orientation toward short-term care in a nursing home rather than long-term care in a community setting, such as one's own home.

The question seems to be, can the current health care delivery system to the elderly survive, and be cost-effective and efficient? The answer seems to be no, and there is a growing trend to create a system of care for the elderly that is appropriate to their needs and is responsible to society's mandate to use its shrinking resources wisely and efficiently.

The concept of long-term care has not been clearly defined, but the assumption is that it refers to specialized health, social, rehabilitative, and residential services provided over an extended period of time to meet one's needs.

It has become apparent that the Federal Government is now redirecting its emphasis toward developing more community-based programs, referred to by planners as a continuum of care (services) delivery system. But there must be caution in planning, not to allow public policy to build a wall in the services delivery system between the elderly in the nursing homes and the elderly in the community. All services to the elderly must be provided in the most cost-effective manner and in the appropriate setting.

For approximately 5 percent of the aged population 65 and older, nursing home care is the appropriate service, and with the proportion of the aged population over 75 growing steadily, nursing home care needs to be available. In reviewing a new direction in health care delivery systems, let's not forget to review how the nursing home industry can be more effective in programing, such as prescreening evaluations or adequate discharge planning. We cannot redirect one system without affecting other systems; the cause and effective approach to change will alter the services available to the elderly in non-institutionalized settings as well as institutional settings.

The Congress, through the Older Americans Act, has given State units on aging and area agencies on aging a responsibility to assure that a continuum of care is developed. The primary goal of that continuum being the development of community-based services that will maximize the independence and self-sufficiency of older people to remain in his/her own home. Despite this mandate and the concerted efforts of personnel at Federal, State, and local levels, such a system has been developed in only a limited number of cases. Successes in developing such systems of community care have often been made in spite of Federal policies and regulations which act as barriers to providing services to older people.

The barriers to developing a continuum of care for older people that we need to address are:

(a) Differing views among disciplines on meeting the total needs of older people, including medical, psychological, personal, and social service needs.

(b) Lack of case management services approach for the coordination of program development.

(c) Lack of an effective accepted needs assessment tool.

(d) Programs that serve the elderly with different funding sources and often times conflicting regulations and rules, eligibility requirements, etc.

(e) No incentive for coordination of program development; and

(f) Biases against nonmedical and noninstitutional care, primarily in the reimbursement mechanism of medicaid and medicare programs.

It is time to rethink our current strategies and eliminate the above mentioned barriers so an effective community care system can be developed. Point (f) above, is presently being addressed in Senator Orrin Hatch's bill, S. 234, cited as the "Community Home Health Services Act of 1981." This proposed legislation encourages the establishment of home health programs by amending the Social Security and Public Services Acts to provide expanded coverage of home health services under the medical and medicaid programs.

Home health care agencies are being considered to be the wave of the future, but numerous reports raise questions about the rapid growth of these agencies and their cost effectiveness. A review of the statistics for North Dakota indicates that services provided by hospital-based home health agencies are more expensive than services delivered from nonprofit agencies. The questions that need to be addressed include: Are home health agencies equipped to be the case management, nonmedical service delivery system for the elderly? Should a totally new home health care component be developed with few rules and regulations? To this end, a number of States have enacted legislation relative to the development of home health agencies in their respective State.

S. 234 is a beginning and should be supported only if coordinational efforts result, and the "new" service delivery system provides for the interrelationship between all service providers, including the nursing home industry. We need to plan so that the newly created system controls effectively for abuse, neglect, and fraud that have been reported in the nursing home delivery system during the seventies and eighties. Inefficiency in program development is costly in times when there is going to be an increase in competition for goods and services among all age groups.

Another very recent attempt to address the health issue of older persons is the option in the medicaid program to broaden the waiver of statutory requirements for reimbursement for community-based long-term care services for States. The question of paying for the development of new services has not been addressed. If under the waiver plan, the philosophy is to replace costly long-term care nursing homes with community-based services, then who is responsible to develop those services and where does the funding come for program development? Will the waiver only be a means of financing the medical aspect of health care, the "swing bed" concept?

It is paradoxical that the homemaker/home health aide program, which directly affects the services to the elderly and their ability to remain in their own homes, is being reduced because of reductions in title XX funds. Yet, there is discussion to reimburse for community-based long-term care services.

Federal, State, and local levels will need to consider the following types of changes:

(a) Medicaid program must be altered to eliminate incentives for institutionalization. For example, financial eligibility standards for those medically determined to be eligible for institutional care should be the same for home health care as for institutional services. New York's program entitled "Nursing Home Without Walls" assesses the individual's need for services, assesses the cost of service delivery, develops a care plan, and provides community services if those services are 75 percent the cost of institutional care in that given locale.

(b) Provide financial incentives for the informal support system, such as family members, which provide care to older people in their homes in the community. For example: tax incentives and cash reimbursements to family care givers.

(c) Provide for a discharge allowance to assist the resident with the "transplantation" from institutional setting to a community setting.

(d) Further support volunteer and employment programs for older people in redirecting their activities to provide additional services to the homebound elderly.

(e) Create the establishment and reimbursement for individual needs assessments and case management services.

(f) Develop linkages among the State plans for titles XVIII, XIX, XX, and title III of the Older Americans Act.

(g) Develop training programs to assist the formal and informal service delivery structures in developing the skills needed to deliver long-term care services.

(h) Enhance family and informal support networks, which are an essential component of the formalized service systems; and

(i) Assign an agency the responsibility for providing the needed technical assistance to States in program development.

Long-term care policies should encompass a full range of health, social, and personal care services which are provided over an extended period of time to older persons who are unable to cope with tasks of daily living or self-care without some assistance. Consideration should be given to a strategy that integrates all long-term care services into a continuum of care (services) program in a given geographical area, rather than one that focuses purely on home health care or nursing home care. This approach is the most realistic approach and possible solution to addressing the health care needs of the elderly.

Thank you for this opportunity to present written testimony on this most important issue.

Sincerely,

LARRY BREWSTER, ACSW.

ITEM 3. LETTER FROM M. EDWIN NUETZMAN, ADMINISTRATOR, HOMEMAKER SERVICES, SOCIAL SERVICE BOARD OF NORTH DAKOTA, BISMARCK, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 20, 1981

DEAR SENATOR BURDICK: In your letter of November 6, 1981, you invited me to attend the hearing on November 14 in Grand Forks, on "Rural Health Care for the Elderly: New Paths for the Future." Because I was unable to attend, I am submitting this testimony.

We are fully in accord with legislation or planning to upgrade training in geriatric medicine, whether the training be for physicians, homemaker/home health aides, or community health nurses. By including geriatric medicine in the curricula of medical colleges, physicians would become more aware of the needs of the elderly and more understanding of the necessity for a service network to meet the health, social, and emotional needs of our senior adults.

It is widely known that senior adults can be productive and useful citizens providing they are in good physical and mental health. Thorough training of health professionals in geriatric illnesses and the social and emotional problems of the elderly will do much to maintain (and perhaps increase) senior adults' productivity and usefulness.

Such training should reduce the incidence of inappropriate and premature institutionalization of elderly persons by increasing home health care services. The "Comparative Homemaker Cost Study," made by the Social Service Board of North Dakota for the months of February and June 1974, found that had our homemaker/home health aide service (started in 1967) not been available, recipients of the service would have spent an estimated 7,793 days in hospitals, skilled nursing facilities and the like, instead of remaining in their homes. By assisting these people to remain in their homes, the cost was significantly reduced: The actual cost of homemaker/home health aid service was $30,657, but the estimated cost of alternative services for these 2 months was $92,829. (Forty-eight percent of the homemaker/home health aide service recipients were studied.)

Besides the savings in home health care, the literature emphasizes that senior adults generally thrive better in their homes than in an institutional setting, and the ill tend to recuperate more quickly in their homes. This also enhances the productivity and usefulness of senior adults.

Preventive medicine can also be practiced more effectively if health professionals are trained in geriatric illnesses along with training in social and emotional problems of the elderly, and in service delivery. Many senior adults in North Dakota live in areas where physicians are not readily available, and distances involved, cost of transportation, along with an inability to provide their own

transportation makes medical service difficult to obtain. Consequently, people have a tendency to postpone procuring medical care until their conditions develop into something serious. The physician's understanding of geriatric problems plus supporting services such as our homemaker/home health aide service, should make early diagnosis easier and allow for treatment in the home instead of having to treat an acute problem in a hospital.

Our homemaker/home health aide service, employing about 190 homemakers and aides, works jointly with community health nurses to assist the elderly to remain in their homes and to have home health care. The cost of our homemaker/home health aide service runs about $10 an hour. Training of physicians in geriatric medicine and to work with a network of supportive services would do much to enhance and increase the effectiveness of our homemaker/home health aide service.

To reiterate, we fully support any plan that will promote sound physical and mental health of senior adults.

Sincerely,

M. EDWIN NUETZMAN.

ITEM 4. LETTER FROM ROBERT M. JACOBSON, PRESIDENT, UNITED HOSPITAL, GRAND FORKS, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 25, 1981

DEAR SENATOR BURDICK: My letter is in reference to your hearing in Grand Forks concerning the above topic. I had the opportunity to be there for part of the hearing but had to leave because my stepmother has just had eye surgery, my wife had an unavoidable conflict, and I had to go home and take care of "Grandma." It's a coincidence that what you were talking about that day had to do with the events that went on in my life during that day.

In listening to the panel members it seemed that there were several themes that came out. There obviously appears to be a need for more concern and more resources. Dr. Janssen made sense to me when he talked about deinstitutionalization and his ideas about nursing homes providing ways in which the individual could keep as much of his own identity as possible.

I think we're in a very serious bind right now. If these discussions had been going on in the early sixties during the time when the United States and North Dakota were significantly increasing their productivity and the overall growth of our economy it would be one thing. We appear to be entering into an era of limits. Many of the suggestions made by individuals were good ones, but I question whether we are going to be able to have them. The home health program is a good example. I think home health is part of the future. We have an excellent program here at the United Hospital. Its kept patients out of the hospital, and its shortened the length of stay of a number of patients who have been in the hospital. On the other hand, its also provided new services to patients who were receiving little or none. In this case, there were no savings in dollars only additional dollars spent. The patients needed the services but I'd ask the question, How long are we going to be willing to pay for that? Dr. Janssen's ideas about making the nursing home more personalized will cost more money. Deinstitutionalization may save money but I'll bet you at times it's really going to increase costs because again I think there will be more people who take advantage of the service.

I think that any solution that we develop are more long range than short. I feel in the short range many of these solutions will cost more money. We're going to have to change people's habits. The United States has spent the last 30 years investing in the system we now have. We cannot throw that system out overnight. During the transition period, some parts of the system may suffer and I'm afraid that person may often times be the patient. Many of the new systems whether they be home care or whatever need to develop gradually so that we determine just what their results really are going to be. If they appear to be productive in the long-term basis then gradually we can phase out of one system to the other. The facts of the matter are that as we continue to improve technology and see individuals live longer that institutions whether they be hospitals, rehab facilities, or nursing homes are going to continue to play a very

significant role. Patients who are 90 years old that need to have their hips replaced are going to cost a lot more than patients who are 60 years old.

From some experience I've been very concerned about the financing for nursing home care. I see my father and mother-in-law, both in a nursing home, using up the last of their resources over the next two years. If they are typical, a point in time will come when they will have to go on welfare and/or their children will have to support them. We're going to do our share, but I'm raising six children and there's just so many dollars to go around. The last thing my father-in-law wants to do is go on welfare. That's even worse than putting him in the nursing home. The system is rather degrading to people with a work ethic in this country.

I don't know what the long-term answer is but what we have now needs to improve. Maybe we the public have got too much of the attitude that we want our cake and eat it too. There are many patients who wouldn't have to be in a home if their families would take care of them or if their neighbors would even be concerned about them. Economics may just force the answer without us doing that much.

I appreciated the hearings you held and the issues raised. Thank you for your consideration.

Sincerely,

ROBERT M. JACOBSON.

ITEM 5. LETTER FROM JANE M. CROEKER, PARALEGAL, LEGAL ASSISTANCE OF NORTH DAKOTA, INC., FARGO, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 24, 1981

DEAR SENATOR BURDICK: Congressional expressions of concern regarding elderly health care needs present some hope for resolution of a major problem confronting senior citizens. My observations of the geriatric health care system in the United States have been extremely disheartening.

Many doctors are prejudiced against elderly patients because their medical problems cannot be cured easily or quickly. Naive physicians do not consider the special needs of older Americans when prescribing medication or relating treatment instructions.

Transportation to health care centers is a major problem for many elderly individuals. Public transportation does not exist in many parts of North Dakota and even when the service is available, it does not meet the needs of the frail elderly.

Lack of community alternatives to inpatient care fuel rising health care costs and limit the free choice of our elders. Home health care, homemaker service, respite care, and physicians who make house calls exist only in the imagination of most rural Americans.

Economic factors nullify most preventive health practices, creating a crisis-oriented health care system for the elderly. Even though most elderly people do not seek treatment unless critical impairments force action, health care costs erode a large percentage of their fixed incomes. Medicare, private insurance, and medicaid do not prevent many seniors from experiencing financial hardship because of medical expenses.

Older Americans are victimized by the complexity and poor coverage of public and private insurance programs. Notices and policies abound with incomprehensible terminology and codes. Medicare covers less than 50 percent of the health care costs incurred by senior citizens. Private companies compound the problem by following medicare's guidelines for "reasonable and customary" costs. Most physicians are unwilling to accept medicare rates and the frail elderly suffer the consequences.

America's health care system must be evaluated and revised to more effectively meet the needs of all elderly individuals. At present, adequate health care is dependent upon the size of one's bank account and the availability of services. I am encouraged by your expressed interest in this vitally important area.

Sincerely,

JANE M. CROEKER.

ITEM 6. LETTER AND ENCLOSURE FROM MYRT ARMSTRONG, EXECUTIVE DIRECTOR, MENTAL HEALTH ASSOCIATION OF NORTH DAKOTA, BISMARCK, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 23, 1981

DEAR SENATOR BURDICK: Enclosed you will find testimony from the Mental Health Association of North Dakota in support of your bill on rural health care for the elderly. The "farm stress" workshops we are conducting serve to identify loneliness and isolation along with other needs not now being met in rural States such as ours. I am forwarding a copy of our "farm stress" manual under separate cover.

All of us associated with the Mental Health Association wish to express our sincere thanks for your outstanding support and work you are doing on the critical mental health appropriation and research bills before Congress. We are well aware of your many efforts and are extremely grateful for what you are doing.

The many volunteers of the Mental Health Association and all of the families in need of the association's services also appreciate your efforts and say thank you.

Sincerely,

MYRT ARMSTRONG.

Enclosure.

STATEMENT OF THE MENTAL HEALTH ASSOCIATION OF NORTH DAKOTA

The Mental Health Association supports the efforts of the Special Committee on Aging establishing innovative means of geriatric medicine to meet the unique health needs of the rural elderly.

The Mental Health Association is the only national volunteer advocacy organization concerned solely with the mental health needs of our citizens. This association is actively involved in community education issues which has included issues ranging from coping with stress, loneliness, or personal concerns to the provision of quality health services at both the community and State levels for the elderly. A specific concern has been the stigma attached to persons who have received treatment in a mental health facility and the concurrent availability and acceptance of resident application at local nursing facilities. Both support inservice education of care givers who are essential. A cooperative effort of those in geriatric health care services to specifically plan for this education is essential and supportive funding to provide this education is necessary.

The needs are many and the Mental Health Association encourages the recognition of these special mental health needs.

We offer our assistance in whatever way we can be helpful in addressing these needs.

ITEM 7. LETTER FROM LEO K. FETTIG, EXECUTIVE DIRECTOR, AND JANICE WAGNER, HEALTH SERVICES, BURLEIGH COUNTY SENIOR ADULTS PROGRAM, BISMARCK, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED DECEMBER 7, 1981

DEAR SENATOR BURDICK: The senior center in Bismarck, N. Dak. has provided a full-time health screening nurse for the past 3 years to all persons 60 years of age and older. The health screening office has been established to coincide with the nutrition program thus making it readily available for all seniors coming to the center for meals or recreation. The services provide blood pressure screening, physicals, hearing tests, diabetic testing, eye exams, nutrition counseling, in-home health screening for homebound elderly, and educational literature on many conditions and diseases. We have also obtained the services of a dentist, medical doctor, and a podiatrist. They examine and screen at the center once a month.

We see an average of about 500 persons per month, and are able to do so effectively with the assistance of senior nursing students from Mary College and the Bismarck Hospital School of Nursing.

We feel the health services that are made available through such programs as the Burleigh County senior adults program play a large role in keeping the elderly in a better physical and physiological condition thus enabling them to stay in their homes much longer. The rising cost of medical services is a major cause of loss of income for the elderly. Our continued monitoring of persons

prevents the need of a clinic visit, for we also keep in close contact with the medical staff of the clinics as well as the various community service agencies.

We feel the success of our program is based on the accessibility of the services that are offered to the participants at a contribution rate they can afford. Therefore they will seek medical help more frequently and more freely.

Thank you for your attention.

Sincerely yours,

LEO K. FETTIG.
JANICE WAGNER.

ITEM 8. LETTER FROM GLADYS BLACK, PRESIDENT; RITA BROWN, SECRETARY; AND MARTHA TORKELSON, EXECUTIVE DIRECTOR, GREATER GRAND FORKS, N. DAK., SENIOR CITIZENS ASSOCIATION, INC., TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 23, 1981

DEAR SENATOR BURDICK: The board of directors of the association unanimously affirmed and endorsed the testimonials of panel members and others presented to your committee. This was done at a regular meeting on November 19, 1981.

Special attention was given to the tesimony of panelist Henry Lundene relating to the "medical van" concept of making health delivery services available to those in remote rural areas. The long- and short-term care situation in rural North Dakota was discussed briefly and deserves further study by your committee.

The testimony of the professional personnel on the panel was of exceptional value as the board discussed it. The structure of the University of North Dakota Medical School merits particular attention from your committee, since it involves four area health centers and utilizes the rural health delivery experiences of the general practitioners in the field. This structure also involves the collaboration of all areas of health delivery services in the State.

The university medical school's "Institute on Gerontology" also includes all the academic and professional disciplines of the university in its structure. This gives the institute a broad base from which to gather information, do research, and become a growing resource facility for aging services in the State.

The hearing session was very fortunate to have Dr. Robert Butler, Director of the National Institute on Aging, present to participate and to gain the benefit of the experience of the professionals and lay persons who testified to your committee.

The Greater Grand Forks Senior Citizen's Association congratulates you on the very fine and successful hearing which you chaired here on November 18, 1981.

GLADYS BLACK.
RITA BROWN.
MARTHA TORKELSON.

ITEM 9. LETTER FROM ANNA POWERS, LEONARD, N. DAK., PRESIDENT, CASS COUNTY COUNCIL ON AGING, TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 25, 1981

DEAR SENATOR BURDICK: I want to commend you for your interest in geriatric medicine. I have heard very good reports of the hearing held in Grand Forks on November 14, 1981. I am sorry that I could not attend but I am very interested.

Our rural senior citizens have come a long way in Cass County in the last 10 years. We have centers or appropriate meeting places for all our 13 rural clubs. We now have a home to program from.

My thought is that some of the knowledge in the care of the elderly could be used here as a preventive measure before we are ill or institutionalized. Our concern is to help our elderly to remain in their homes and communities as long as possible.

Once geriatric medicine is taught, I would hope that there will be a way to educate us at the grassroots to help ourselves as a preventive measure.

My husband has been ill for 50 years and has been an invalid for the last 5 years. I still care for him at home and I want to continue. This is only one case and there are many more. I am concerned about the increase in numbers of elderly and the education they should receive to benefit themselves.

Thank you and good luck.

ANNA POWERS.

ITEM 10. LETTER FROM ESTHER THOMSEN, UNDERWOOD, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 11, 1981

DEAR SENATOR BURDICK: I am sorry I cannot attend your hearing on rural health care for the elderly, which is to be held in Grand Forks on November 14:

As a board member of the McLean/Mercer Commission on Aging, I am very aware of some of the problems for the elderly.

Since we've had the meals-on-wheels program, I can see the good that is happening. The last time the health clinic was held in our town the nurses found an elderly widower who had malnutrition. I'm sure his diet has been mostly bread. The nurses were able to convince him he should come every day for his dinner. I wish you could see the change in him. Yesterday, I'm sure, he had had a bath and was dressed up. He looked so nice.

My husband who has had the privilege of delivering meals to the shutins, says "I wish some of the legislators could have this experience. Their gratitude would melt even the hardest heart." We can't afford to go backward after the progress that has been made in this field.

But we still have the overwhelming problem of meeting the matching funds. North Dakota doesn't have State funds to carry on these programs and our resources for meeting these expenses just aren't sufficient. We were warned by our regional director for the Commission on Aging that we might not be able to carry on our nutrition program in our county next year, especially with our lack of matching funds.

There has to be legislation to meet this need. Thank you for your efforts in the behalf of the elderly.

Sincerely,

ESTHER THOMSEN

ITEM 11. LETTER FROM GWEN L. SOLIEN, ADMINISTRATOR, AMERICANA HEALTHCARE CENTER, FARGO, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 12, 1981

DEAR SENATOR BURDICK: Thank you for your letter of November 6, 1981, regarding the field hearing in Grand Forks. Our social worker, George Wright, is attending the Friday session, but we will not have anyone there on Saturday.

I do think the medical school could (and does to some extent) afford rural North Dakota continuing education in health care for the elderly.

Dr. Reiff, George Wright, and I presented a free 1-day seminar in Fargo last January as Americana's "gift to the community." We are already in touch with Dr. Reiff for another program for this winter. Part of the program will deal with overuse of medications, effects of certain drug regimens, etc., and the seniors in our community will be special guests. I believe Dr. Reiff feels strongly about his responsibility in the area.

I agree that providing more opportunities in medical schools and nursing schools for exposure to geriatric medicine is one of the best ways to improve health care for our elderly residents. I certainly know that our nursing homes would benefit from this.

Senator Burdick, I am concerned about a trend I see throughout the country. In the Fargo-Moorhead area, we have at least three old buildings being renovated for housing for the elderly. With a little home health thrown in, these places could become "nursing homes" without regulation—not intentionally, but it could be a creeping problem.

Also, I would like to point out that home health (in most instances) is not cheaper than a nursing home and if tax dollars are to pay the bill, then I believe that someone on medicaid should have to accept the most economical program available that would meet the need. If inflation continues to plague us all, I too will need to make such a prudent choice some day.

Good luck with your efforts regarding the elderly and your work on the Appropriations Committee.

Sincerely,

GWEN L. SOLIEN.

ITEM 12. LETTER AND ENCLOSURE FROM LOYD KEPFERLE, GENERAL DIRECTOR, MOUNTAIN STATES HEALTH CORP., BOISE, IDAHO, TO SENATOR QUENTIN N. BURDICK, DATED NOVEMBER 25, 1981

DEAR SENATOR BURDICK: The enclosed material represents the statement of the Mountain States Health Corp. to the U.S. Senate Special Committee on Aging. Priscilla Ebersole and I attended your hearing in Grand Forks on November 14, 1981. While in Grand Forks we had the opportunity to present our views and information regarding geriatric nurse practitioners to the North Dakota Gerontological Consortium as well as attend the lecture given by Dr. Robert Butler of the National Institute on Aging.

We are impressed by the efforts being made in North Dakota to deal with the problems of the rural elderly. Those problems exist in most of the Plains and rural Western States and it is apparent that North Dakota may serve as a model for other States with similar circumstances.

If there is any way the information or models related to our activities can be of service to the Special Committee on Aging, please let us know.

Thank you for the opportunity to submit written testimony.

Sincerely,

LOYD KEPFERLE.

Enclosures.

STATEMENT OF THE MOUNTAIN STATES HEALTH CORP.

This statement was prepared by the staff of a 3-year demonstration project to improve the quality of care in skilled nursing facilities. The project, "Improving Quality Care in the Skilled Nursing Facility in the Rural Mountain West," funded by the W. K. Kellogg Foundation, is being conducted by a nonprofit corporation, the Mountain States Health Corp., of which I am the general director. The Mountain States Health Corp. is a public nonprofit resource development organization whose mission is to assist citizens, health care providers and organizations to improve the delivery, accessibility, and quality of health care services. This 3-year project, conducted in the States of Wyoming, Montana, Idaho, Oregon, and Washington, is based on a well-founded assumption—the future improvement of the quality of care in nursing homes is directly related to the presence of a geriatric nurse practitioner on the staff of a nursing home where she works in a close team relationship with a physician, preferably the medical director.

These comments were prepared jointly by Sidney C. Pratt, M.D., and John W. Gerdes, Ph. D., codirectors of a project designed to demonstrate that the introduction of a geriatric nurse practitioner as a full team member will, through her unique role and new capabilities, elevate the quality of care.

The staff had an opportunity to become well informed about the level of care in 21 nursing homes in the Northwest. They could be characterized by industry standards as being of "good" to "high" quality. In each facility we examined a sample of the medical records of patients discharged during the previous year, talked with nursing and medical staff members and administration in each of the homes. Based on our more than 2 years' experience in these 21 SNF's and based on our accumulated previous experiences, we have arrived at some conclusions that we feel are of value to this public meeting.

It is in the context of these detailed observations and interviews that the following comments are offered.

It is our belief that all care must be rendered by competent, trained personnel. Recognizing that there are various levels of care to be offered to the residents of nursing homes, not all personnel need acquire the status of certification or licensure. The major portion of the professional care must be supervised and/or administered by licensed health professionals, i.e., physicians, R.N.'s and L.P.N.'s who are licensed to practice their professions and who, by virtue of this licensure, have completed the required basic and specialized educational curricula that has led to their licensure. Beyond that, care is being rendered by personnel who have not attained the level of education required for licensure, i.e., aides and orderlies. These personnel must be supervised closely by the licensed professionals and their activities must be limited to those elements of care com-

mensurate with their training. Inherent in this is the necessity that continuous and continuing orientation and inservice education activities are essential to maintain high quality care.

It is our observation that the nursing home industry is virtually overwhelmed by regulation. Every effort should be made to simplify standards and regulations while, at the same time, increasing concentration on those aspects that relate to patient care. In this connection the third option, developing a single set of standards applicable to SNF's and ICF's, would be a step in the direction of simplification. As regulations now stand they are essentially self-defeating for small nursing homes with a limited staff. Far too much time is spent in achieving minimal or paper compliance leaving little time for constructive planning, supervision, and program improvement.

In surveying and certification we favor provider agreements of at least 2, and preferably, 3 years in length retaining the present public agency responsibility for surveying and certification. Again, we urge a simplification of the survey detail which has become a choking end unto itself rather than a vehicle for safeguarding or improving care of patients.

Turning now to the issues that we feel would be useful to the U.S. Senate Special Committee on Aging.

(1) In general, we support the need for a standard that requires minimum qualifications for professional personnel. However, we urge that consideration be given to rural communities in which there are virtually no professionally qualified personnel. Is there not a way of building in an exception that would not require closing of a facility for lack of qualified personnel if, in fact, the facility is providing a needed service within the community?

(2) In reference to the administration of medications by unlicensed or untrained personnel ("medication aides"), it is our strong feeling that in no way should this type of a program be implemented. The safe administration of medications entails a basic knowledge of pathophysiology and pharmacology, particularly as related to the peculiar reactions of the elderly to medications as opposed to the younger individual. The understanding of this one aspect of patient/resident care requires as a minimum those educational experiences that are required for full licensure in the health professions.

(3) On the basis of our examination of a sizable number of medical records in many nursing homes that are widely separated geographically, we can unequivocally say that the medical direction requirement in the present regulations does not insure that patients receive appropriate medical and other services on a timely basis. The physicians, administrators, and nurses with whom we have discussed this issue consistently express the view that physician participation and care of nursing home patients is grossly inadequate. Physicians are slow to respond, exhibit a disinterest in elderly patients, and do not seem to wish to be significantly involved.

What the medical director does, and what he should do, regardless of the regulations, are two vastly different matters. We are convinced that the medical director's role in the nursing home must change. He must be encouraged to be more than a policeman-enforcer of his colleagues. He must have the realistic opportunity to find satisfaction in the challenge of providing care. It must be professionally satisfying as well as remunerative. We strongly urge that medical director regulations be modified to encourage his direct participation in the care of patients within the nursing home. This can be done by making regulations that explicitly encourage physicians to refer patients to the medical director for care and/or make it clear that a facility medical director will be seeing all patients admitted to a facility when they are admitted and on a regular basis thereafter. This deliberate expansion of the involvement of the medical director will, in our view, require that the medical director become more sophisticated in the care of geriatric patients; he will establish his own professional identity as a physician who is well qualified in this field. The referral process, once initiated within a community, will become a natural sorting process that turns the medical director role from one of paper compliance to one of patient care.

Recognizing that the vast majority of facilities do not have a full-time or sufficiently part-time medical director to offer appropriate medical direction on an ongoing basis to all of the residents of the facility, a team of physician and specially prepared nurse is going to be essential to the ongoing care of the resident/patient. This close colleague teamwork in which the R.N. with additional training to certify her as a geriatric nurse practitioner, family nurse practitioner

or adult nurse practitioner and the physician, will lead to marked improvement in the quality of care given.

Recognizing that in the vast majority of instances the physician is not in attendance at frequent intervals, it is inherent in the development of good care that the nurse practitioner, who could be in attendance, be given additional training skills in physical assessment, patient observation, and understanding of the disease process of the elderly, in order for her to assess daily changes that may occur in any one resident. She and her physician colleague, using jointly prepared protocols, are in a position to report or act upon changes in the patient's condition. It is this level of relationship and teamwork that we urge be developed in all long-term care facilities. This goes beyond the minimal qualifications for professional personnel, and, as such, should be given serious consideration in the proposed modifications of the present standards. This would place more emphasis on the quality of care and services provided.

On the basis of our experience to date it is very clear that a well qualified geriatric nurse practitioner working as a team member or as a colleague of a medical director can share in providing superb care.

(4) Regarding the medical direction requirement, it is our opinion that in the mere compliance with the 30-day—60-day visiting requirement, less than adequate care is being given to the patient. Recognizing that physicians react negatively to a visit that is timed according to a regulation timetable, rather than to the need of the individual resident, and recognizing that the vast majority of physicians are sufficiently interested in their patients to visit when there is a medical reason, we feel that changes in the regulations should be made to accommodate the medical, rather than the political, timing. In view of this we feel that two distinct steps should be taken to improve this situation. First, as had been mentioned previously, the development of the nurse/physician team in which the nurse is given more responsibility to assess, evaluate, report and/or treat the patient's changing condition, should be incorporated in new regulations. In those facilities where there are, in fact, certified nurse practitioners, the visitation of these nurses should be accepted by regulation as being an adequate alternate for the visit of the attending physician.

And second, the duties of the appointed medical director should be expanded to make it possible for him to give appropriate attention to all residents/patients in the long-term care facility irrespective of who is the attending physician. Obviously, this will require cooperation on the part of all physicians but there should be developed a definite understanding so that the medical director may take this prerogative without fear of professional retaliation because of his "infringement" on the rights and prerogatives of other staff physicians.

In summary, we observe that it matters little whether "required" physician visits are 30, 60, or 90 days, or whatever. That rigid, artificial requirement can only discourage continued paper compliance that contributes to the round-robin of misplaced responsibility for enforcement that shrouds the patient-physician-nursing home relationship. We urge that the requirement be discontinued and regulations be promulgated to encourage the direct involvement and obligations of a medical director in direct patient care. Again, our project illustrates the easy workability of geriatric nurse practitioner-physician team in which the GNP sees the patient frequently and utilizes her excellent patient assessment skills to translate incremental changes in the patient's condition into action that involves both the GNP and the medical director.

(5) Our project strongly favors the use of well prepared geriatric nurse practitioners. In fact, we see no better alternative. It is simply commonsense to build upon the existing professional skill of nurses who are committed to long-term care and who currently bear the major responsibility for providing care in nursing homes in this country. The nurse practitioner relates to the nursing model of care and can function effectively in this role by working closely with the physician as a team member. The physician's assistant, by popular definition, is part of the medical model of care. As such we do not feel that he is an important an individual in quality care in the long-term care facility as the nurse practitioner. In addition, the nurse practitioner is a licensed individual and in most States the physician's assistant is not licensed. Whether this is right or wrong is beside the point for this discussion. The one fact remains—the nurse practitioner in her expanded role is indispensable to good patient care.

We do not believe the GNP must be employed by a physician. We would prefer to see her as a paid member of a nursing home staff with her first obligation to

patients in that facility. We have observed this arrangement which in no way precludes her working closely with the medical director and/or other physicians. We firmly believe that the working relationship between the GNP and her physician backup should be governed by written responsibility in patient care. A good working relationship must be characterized by mutual trust and respect. It has the potential for maximizing the skills of the individual professions—one provides technical, medical backup, and leadership; the other provides a highly skilled observer and assessor, a listener and a care provider in a situation that is best suited to the use of a well-prepared nurse.

We believe that either the nurse practitioner or the physician should complete histories and physicals at the time of admission with repeat physicals at least annually thereafter. This requirement should apply in both SNF's and ICF's. Both the GNP and the physician should make entries in the patient's record. Both should be able to order medications and other therapies that are clearly covered by their mutual agreement as expressed in prepared protocols. Where there is doubt or where action that is not specified in a protocol is required, the physician must clearly be the one that authorized the care and bears final responsibility for the outcome.

This relationship is intended to establish areas of responsibility that are realistic rather than continue to hide them under the historic, generalized "physician is responsible" concept when, in fact the physician's responsibility is not specific or meaningful when he is not directly involved in a day-to-day decision.

In the described relationship there is a need to modify the rigid requirement for a physician's signature. We would much prefer to see an open recognition of the responsibility of a well-prepared nurse practitioner and the related responsibility of a physician. Consideration must be given to accepting signatures of a nurse practitioner after establishing the conditions under which that arrangement can exist.

(6) The order of the elements listed in patient care management could be improved. By far the most important part of a patient's care is related to the assessment and thought that are the foundation for a realistic patient care plan. In addition to the activities projected in a patient care plan we strongly urge that measurable goals and schedules for achieving those goals be specified. If there is not time incentive included in a plan, it is too easy to allow inactivity and wasted time to characterize the care. It is as if there is always a tomorrow!

In order to take a patient's care plan out of a dark closet we also urge that those plans be reviewed with the patient if he/she is capable of participation and/or with patient's relatives. Open discussion requires the nursing home staff to put its anticipation "on the line." Sharing a care plan with a patient and family adds another useful pressure for achievement. We also believe that the initial assessment should be made within 10 days of admission so that an active therapy program can be initiated and an earlier discharge anticipated.

Among the categories of "physician extender" described, we believe that the geriatric nurse practitioner, working with physician backup in a team relationship, is the best choice for concentration of resources and skill development as a national policy.

In June 1981, the W. K. Kellogg Foundation provided a 3-year grant to the MSHC to facilitate the training of 85 GNP's in 11 Western States. Our intention is to provide a model utilizing GNP's from which those interested in improving the care of the elderly can garner useful information. We are confident that the logical progression will lead to a national acceptance and institutionalization of GNP's in the care of the elderly.

Thank you for the opportunity to present this statement. I should like to commend you and the committee as well as your staff for making this effort to solicit comments from informed and interested respondents. If we can provide additional information that might contribute to improving the quality of care through new directions we would be pleased to do so.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

Dear Senator Burdick: If there had been time for everyone to speak at the hearing on "Rural Health Care: New Paths for the Future," in Grand Forks, N. Dak., on November 14, 1981, I would have said:

The following replies were received:

Darlene Barthel, R.N., Mott, N. Dak.

Let me introduce myself. I am Darlene Barthel, R.N., nursing supervisor and assistant administrator of Southwestern District Health Unit, an eight-county health district here in southwest North Dakota.

I was privileged to be present at your public hearing in Grand Forks, entitled "Rural Health Care and the Elderly," and would like to add the following comments.

First of all, I would like to echo the feelings of the panel and public in the area of home health care. It is becoming increasingly popular in our area. Just this past year, our district entered into a contractual agreement with all eight county social service boards, which provides for reimbursement for nursing supervision of home health aides. As one who was involved in setting up the program, I can attest to its value for both agencies.

We here at Southwestern District Health Unit also have a health maintenance program, funded under a grant from Aging Services, which last year provided over 400,000 services to over 12,000 people. These services included monthly clinics for monitoring blood pressures, weights and pulses, and included yearly screenings for glaucoma, diabetes, hearing, vision, urine, and hemoglobin. Nutrition counseling is also available and nurses make referrals to other agencies as needed.

I enjoyed your appearance and hope you will continue to support health care legislation.

Earl Boyd, Rock Lake, N. Dak.

I was at the meeting November 14. I would like to ask some questions about the care of the older citizens.

Why is the cost of rest homes so high for the care that they get. I have seen old men and women abused and not cared for in the right manner. $1,500 is a very big cost for 1 month. Most senior citizens around here do not have much money saved up. Maybe $10,000 or $15,000 in 1 or 2 years and they are broke and at the help of the government. How would you feel if you were in this class? Why do the older people have to have three or four people to tell us how to live and eat? How do you think we got to be 75 or 85 years old?

I am very much in favor of more of the money spent on care for the senior citizens. Please excuse my writing. I did not get past the eighth grade. I am 71 years old. Am in good health yet. But I hate to see the older ones treated like some of them.

Thank you for letting me write to you.

ROSALIE BAER, FORT TOTTEN, N. DAK.

In reference to title VI, the legislation that authorizes direct funding for tribes to develop and operate their own aging services. The Devils Lake Sioux Tribe needs this direct funding to operate elderly programs on the reservation and to provide necessary nutritional and social services to the elderly. The majority of the elderly on the reservation are rural and isolated, and dependent on the senior meals and services and elderly transportation for these necessary services.

The Devil's Lake Sioux Tribe also needs an elderly homemaker program for visitation and assist homebound elderly.

Last but not least, the low-income energy assistance program is vital to the elderly on the Devils Lake Sioux Tribe reservation because of limited incomes and harsh winters.

KATHLEEN A. COOK, R.D., AND JANICE SCHUH, M.T. (ASCP), GRAND FORKS, N. DAK.

As health care professionals, we are very concerned about the care provided the elderly citizens of North Dakota.

Our areas of concern are:

(1) Transportation. Financial aid to continue enabling them to finance a bus to provide transportation to the elderly citizens. Transportation to regional medical centers, shopping centers, or area social events.

(2) Mobile health unit. We would like to see North Dakota have a mobile health unit similar to the one in Polk County, Minnesota. This could travel to communities providing minimal health screenings.

(3) Nutritious meals. Would like to see a home-delivered meal service or congregate seni[illegible]al sites available in each community in the State. Adequate nutrition is most important for the elderly. Only through proper nutrition do the elderly have a chance to slow down many of their common diseases (hypertension, diabetes, heart trouble, or malnutrition), and hopefuly maintain optimal health.

(4) Congregate housing-apartment complexes. Had an opportunity on Monday evening to view the Helen Hayes film on PBS concerning aging in the United States. The entire film was very good. I was impressed with the part on congregate housing at Ebenezer in Minneapolis, Minn. When feasible in North Dakota, we would like to see some type of housing with access to medical facilities and social events.

Thank you for the opportunity to attend this hearing and to be able to submit this testimony.

EVALON CROWS HEART, HALLIDAY, N. DAK.

The elderly of the Twin Buttes and Halliday area, especially the Twin Buttes area, are presently without a doctor. The Indian Public Health Service got rid of our doctor in Twin Buttes. If the elderly get sick now, they need authorization from IPHS in New Town in order to get any kind of medical attention. If they don't have that authorization, then they (the sick elderly) do not get medical attention. They are often turned away at the hospital.

Twin Buttes presently does not have any kind of health care for its senior citizens. What is being done about this problem? We need attention, we would welcome pilot programs here in Twin Buttes if this is the only way for us to get our health care. All too often, other parts of the Ft. Berthold Reservation get the things that Twin Buttes needs very desperately.

Thank you.

LOU DEMARAIS, BISMARCK, N. DAK.

When medicare and medicaid legislation was passed in 1966, it tapped what was believed to be an ever-flowing well. Federal dollars were made available for hospital and nursing home care for our elderly, regional medical programs, health planning, health education, day care programs, and programs in home health care. All of these programs prospered, except home health care. An array of Federal and State agencies were also created to administer the flow from the

everlasting well. These public agencies, however, spent much of their time grabbing for new "turf."

Listening to our elderly and the report of the North Dakota White House Conference on Aging has made me suspect that our national health care policy that was established in 1966 has, for the most part, been a failure.

Today, the public cries for reason and realism. Government spending for health care for the elderly has to be more directed and defined, and the ever-flowing well that placed many of our elderly in institutions has got to be restricted. It is time to redirect the flow toward more community, noninstitutional programs with an emphasis on home health care. In doing so, the private sector should not be ignored. They have the expertise and vision to provide service of equal quality or better, at less cost than the public sector. The 9-to-5 public agencies are generally not concerned with cost or efficiency, as they are tax supported and subsidized. I believe that the old (hopefully not forgotten) concept of free enterprise and competition can get the job done better than those promoting the free flowing well concept that is administered through public agencies.

HELEN L. DOELING, DUNSEITH, N. DAK.

Since prior commitment prevented me from being in attendance at your hearing relative to senior citizens in Grand Forks, N. Dak., I would like to express my appreciation for your work in the past and my hopes for your continuation in the future. Since the percentage of elderly is the fastest growing segment of our society, we are all going to have to work on the areas that concern keeping them healthy, independent, and self-sufficient—to keep them not only living, but living with dignity. For this, we need geriatric medical research and programs that are available to the elderly where they are, and not where it is convenient to the workers. They need outreach and the information that this is not "welfare." This is communication. They need home health care and chore help, and they need transportation available to help them get to their shopping, churches, and medical centers. They need, desperately, the meals program that gives them balanced meals as well as a warm comforable social interaction.

And they desperately need the security of their social security. And if we want to be very dollar and cents minded, and leave out the human factor, we see that we cannot afford to leave these programs fall by the wayside. If, for instance, we can keep just one senior citizen out of a nursing home for just 1 year, we can just about support or pay for the meals program in our little town for that same year. Keeping just one person independent with home health care or chore service would again pay for that entire program.

Again, we all are going to have to work toward keeping our elderly productive, self-sufficient, healthy, and living with dignity. This is what I want for you, and for myself; for I, too, plan to be a senior citizen—the alternative isn't all that great.

I appreciate your keeping us informed as to your direction and progress. Then I can, in my own small way, do what I can to help.

PRISCILLA EPERSOLE, R.N., M.S., BOISE, IDAHO

Older Americans are over medicalized and overtreated by undereducated physicians who do not understand the limits of homeostatic adaptability in the very old. Geriatric medicine must be delieverd in a holistic manner. If each division of medicine continues to view the parts without the whole, they will continue to function as the blind men with the elephant in the old Indian parable. In our case, the elephant (our aged population) will become even more frail and debilitated. We contend that efforts to teach geriatric care should be moré strenuously applied in nursing.

Nurses provide comfort, care, and coordination, are less single minded in their devotion to cure, and, if given geriatric expertise, know exactly when the aged need the attention of a physician for a specific illness or a multiplicity of illnesses. The emphasis on geriatric medicine is important but better left undone if it continues to fragment the patient into 20 small specialties.

DR. LORIN GAARDER, BOISE, IDAHO

There has been insufficient attention given to maintaining wellness and functional capacity of the aged. It is well recognized that many elders need extensive medical and nursing services, but the greatest majority need assistance and education in maintaining health. They need health supports, screening and information to avert the development of more serious disorders.

Elders are most interested in protecting their health and independence. Wellness clinics, self-care packages, and screening services must be made accessible at low cost in all communities. If we as a Nation are really more concerned about the health status of the aged rather than the perpetuation of professional group interests, we will respond by relinquishing our view of the aged as totally comprised of an illness-prone population and assist them in health maintenance.

DR. JOHN GERDES, BOISE, IDAHO

Geriatric nurse practitioners working as a team with physicians from many specialties have been successful in upgrading the care of the aged in many community and long-term care settings.

A geriatric nurse practitioner is educated in the special needs and capacities of the aged, in a program requiring 1 year or more beyond basic R.N. education. They are able to assess and monitor the patient's health status and needs. They make more judicious and effective use of physician's services and improve the quality of life for persons under their care.

It is unnecessary for most patients in long-term care to see a physician every 30, 60, or 90 days. An alert geriatric nurse practitioner will call the physician only when needed. The application of this single concept would save at least 30 percent of the cost of long-term care.

We advocate the full use and recognition of geriatric nurse practitioners in a radical rethinking of what nursing home really means.

SYLVIA HANSEN, HILLSBORO, N. DAK.

I have worked in the position of social worker for Traill County, N. Dak., for the past 14 years and have had as a major part of my caseload the elderly.

I am genuinely concerned about the medical care received by our senior citizens. Our major form of health care is nursing home care. We lack a continuum needed for less costly and less restrictive care.

We have no basic care facilities in our area and few interim care beds. Our payment system is such that it often pays only for institutional care. Our minimal services for home health care and meal delivery are threatened by the cuts in Federal funding.

My experience shows that many of our elderly would prefer to remain at home and can with some home care service. Please look at a way to fund this helpful and economically sound type of service.

JEROME J. HOEPPNER, GRAND FORKS, N. DAK.

The biggest problem of the elderly is paying the average $18,000 a year for care in nursing homes. This problem is not only for those of rural communities, but for all. What can a prudent man do to provide for such expenses after his earning powers has declined to zero? How can anyone prepare for such expenses in old age?

If an individual has a home worth $60,000 and a little nest egg of money set aside, if he is blessed with longevity combined with a need for nursing home care, he is broke within 3 to 4 years. Inflation is one of the things that certainly is breaking the backs of our elderly. Many of those of 70 to 80 years of age have never known wages of $4 an hour. They worked many of them, at wages of 30 cents an hour back in the late 1930's and 1940's.

The younger people, those of 60 or the whereabouts, with parents in the 80-year-old bracket, are also in trouble because society wants them to help pay

the costs of their parents in nursing homes. In many cases, these people are over their prime wage earning years and are hard put to keep up with inflation. Health care to the elderly and inflation are horrendous problems that seem to have no adequate answer.

SHIRLEY KULEVSKY, GRAND FORKS, N. DAK.

Food stamps can help maintain good nutrition in the low-income elderly and thus maintain health, yet many elderly will not ask for food stamps because of the welfare stigma. I think some thought could be given to making food stamps more acceptable to the elderly. Perhaps they could be given another name or delivery mechanism for the elderly.

THOMAS A. O'BRIEN, HAMPDEN, N. DAK.

Many older people who are left alone are placed in nursing homes primarily because their relatives don't want the responsibility of taking care of them. Many times, they do not need nursing care. And it must be very depressing to them to have to live with people that do. If more senior housing could be provided in small towns and more senior center activities, plus some mobile health programs, these people could be much healthier and happier and at much lower cost to the public.

HELNY OHNSTAD, GRAND FORKS, N. DAK.

One of the great tragedies in America today is the inhuman, merciless treatment of our hospitals toward its elderly patients. These senior citizens are the very people who, during their productive years, sacrificed and struggled to build these hospitals so that they would have the assurance of medical attention if they should become ill. Now, even though they have paid high hospitalization insurance premiums all their lives, and although they may be perfectly willing and able to finance their own expenses, they are told that their stay in the hospital is terminated and that they have no recourse to that decision. Many are discharged from the hospital when at death's door. When is a person more ill than when he is dying? Are hospitals no longer for the sick?

I can mention many incidents that have come to my attention. Last July, for instance, the citizens of my home community of Fairdale were shocked and angered at the shabby treatment extended to one of our respected and well-loved citizens. Until about age 70, he had been a mechanic, always on hand to repair machines so vital to farming operations of the area. Instead of retiring, he chose to move to Grand Forks to accept work that was perhaps a little less exhausting. But last spring, he became ill and learned that he had lung cancer. He delayed going to the hospital as long as possible, but on July 4, it became necessary that he be admitted. It soon became apparent that his life was nearing an end. Nevertheless, his ailing wife was given the disturbing news that her husband could no longer stay in the hospital. She also learned that there was no vacancy in the local nursing homes and that her husband would be transported by ambulance to a nursing home in Grafton. The transfer was made, and the patient died within 48 hours of arrival. Could he not have been allowed his last hours in the hospital? Could his wife not have been spared the terrible trauma of having him moved to a different city? Much emphasis today is placed on our "rights." What rights can a dying man defend?

The above is not an isolated case. Another fine, respected friend suffered from cancer of the throat. He could no longer swallow and he could no longer speak. He weighed less than 80 pounds and suffered much pain. For years, he had carried insurance, and he was also capable of paying his own bill if need be. But he, too, was given the message that he must leave the hospital. He was transferred to the nursing home where he died 11 days later. The episode can never be forgotten by his family.

Another personal friend who was afflicted with emphysema, heart problems, anemia, skin cancer, and advanced age, was also told she must leave the hospital after a short stay there. She could not care for herself at home. No one could be

found who would care for her 24 hours a day. There was no vacancy at local nursing homes. I shall never forget her agonizing statement: "There is no room for me anywhere except in the cemetery." Should our decent, hard-working, sick citizens, be treated thus?

We shudder at the thought of Hitler's holocaust when he eliminated not only the innocent Jews but also the aged, the handicapped, and all unproductive persons.

Some day we may be the older generation. What treatment can we then expect?

MARCIE PARKER, GRAND FORKS, N. DAK.

I would like the committee to be aware of the Consortium on Gerontology, an association of all the colleges and universities in North Dakota. The Consortium is concerned with the problems of the State's elderly citizens. The Consortium is funded by the aging services of the State social services board. The Consortium on Gerontology goals are to assist the educator in formulating and using gerontology resources; to train and retrain service providers in working with the elderly; to sensitize participants to the problems and needs of older people; to serve as a forum for the exchange of ideas about aging; to provide participants with basic concepts and skills for adjusting to aging. At the present time, the Consortium accomplishes its goals by putting on at least four major workshops a year with nationally recognized experts backed up by panels of North Dakota experts in gerontology. We also maintain a large and growing videotape library on gerontology topics, available to colleges and agencies throughout the State for training sessions. We are also serving the State as a networking hub and clearinghouse for information on gerontology. We serve a very diverse audience including: State and local personnel who deliver aging services, students and faculty interested in gerontology (either for personal family reasons or as a future career), and members of North Dakota's aging population.

It seems to me that the Consortium on Gerontology serves as an ideal vehicle for local, grassroots, hands-on worker and elderly client input into the colleges and universities for the needs and wishes of the elderly. At the same time, the Consortium on Gerontology is the vehicle for new ideas and research from the colleges to be shared with the local providers and the elderly themselves. It is for this reason that I wanted the committee to be aware of the Consortium on Gerontology.

Thank you for this opportunity to testify.

EVA M. ROISUM, HILLSBORO, N. DAK.

I wrote you a while back about we people who need the hou maker-health aide program to continue. In my previous letter, and I say again, they do the work for we who can no longer do the tasks. They do so very efficiently. Without their help, where would we go? What would we do? The nursing homes are filled. I for one, if a space was available, would soon be on welfare.

You replied to my letter, Senator Burdick. Maybe you have letters on file that you sent and one I sent to you. You gave me and others I read your letter to a positive feeling, that the program was more important than some others.

I ask again at your meetings to weigh all things carefully before voting. We pray to our dear God it will be to have us stay in our apartments and keep our homemakers doing our tasks.

FRED E. SNYDER, GRAND FORKS, N. DAK.

So many times my wife or I go to the clinic and they have no compassion for we the elderly. One doctor told my wife to go home and do for herself as good as he could do. Why would a person pay such high cost then have a doctor be so rude and give no help.

Also, one doctor told her because of her age he wouldn't do much for her. All they want is money; they know we are on medicare, and they would just as soon have us dead.

I was at the meeting, but found it was just a big smoke screen. All the government wants to do is get us brain washed and build up our hopes for some medical help to pay our cost for care. All they want to do is write out a prescription and keep us on drugs.

TINA STEENSON, HILLSBORO, N. DAK.

Living in our home or apartment is conducive to better environments and adds to less strain physically, mentally, and spiritually for us elderly folk. Having a homemaker come in and doing for us the things we cannot any longer do is very uplifting. I find in my one case, as I cannot see to read or go places as I used to.

God bless you for helping us who no longer can help ourselves.

AGNES J. THORSTAD, R.N., HILLSBORO, N. DAK.

Social service got funding, in the past, from the Federal Government; the Federal funding for home health aides has been withdrawn and many of the people in Traill County who were receiving this service feel they would have to go into a nursing home, as they would not be able to remain independent without help.

Longevity has increased health problems for all, including the medically indigent. Many of our senior citizens do not have any close relations living near them who are able to help them; many senior citizens are living alone and with a little bit of help are capable of remaining independent.

Due to early hospital discharge, many of the citizens need followup care in their home, such as wound dressings, colostomy care, physical therapy, etc. Some of our citizens are home-bound with a physical disability and are unable to care for themselves while the spouse is working. Nurses are involved with teaching family members in caring for someone home-bound in the areas of nutrition, treatment, etc.

The public health nursing office gets many referrals from doctors in other areas, requesting a home health aide and nursing service followup of patient's discharge from hospitals. Home health aide services would provide the continuity of care of those in need. There is usually a long waiting list in nursing homes, consequently leaving no facilities available for people with health needs confined to their homes.

Nursing home costs are catastrophic for most families and after their savings have run out, they end up on welfare paying for the nursing home care.

ELEANOR WILCOX, DEVILS LAKE, N. DAK.

There is a need to protect the elderly from unscrupulous insurance salesmen selling nursing home insurance to senior citizens. Many of these policies are not needed and not authentic. The same applies to extra insurance sold to the elderly to supplement medicare.

In my work as outreach worker in senior meals and services in Devils Lake, we found a client who had handed over $600 to such a salesman. The policy she received stated the premium was $319 a year. She had given him cash. After a great deal of appeals for help to our State attorney general crime investigator, we recovered the money.

Do feel the laws should be strengthened.

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